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ABSTRACT

The intent of this book is to present information on various counseling approaches for drug abuse used in some of the best known and most respected treatment programs in the United States. In an effort to make the comparison of the various models less difficult and to clarify how the model is applied in practice, each chapter follows a specific format. The format includes the following information: overview, description, and rationale; contrast to other counseling approaches; format; counselor characteristics and training; client-counselor relationship; target populations; assessment; session format and content; and role of significant others in treatment. Chapters are: (1) "Dual Disorders Recovery Counseling" (Dennis C. Daley); (2) "The CENAPS Model of Relapse Prevention Therapy (CMRPT)" (Terence T. Gorski); (3) "The Living in Balance Counseling Approach" (Jeffrey A. Hoffman, Ben Jones, Barry D. Caudill, Dale W. Mayo, and Kathleen A. Mack); (4) "Treatment of Dually Diagnosed Adolescents: The Individual Therapeutic Alliance within a Day Treatment Model" (Elizabeth D. Jorgensen and Richard Salwen); (5) "Description of an Addiction Counseling Approach" (Delinda Mercer); (6) "Description of the Solution-Focused Brief Therapy Approach to Problem Drinking" (Scott D. Miller); (7) "Motivational Enhancement Therapy: Description of Counseling Approach" (William R. Miller); (8) "Twelve-Step Facilitation" (Joseph Nowinski); (9)"Minnesota Model: Description of Counseling Approach" (Patricia Owen); (10) "A Counseling Approach" (Fred Sipe); and (11) "A Psychotherapeutic and Skills-Training Approach to the Treatment of Drug Addiction" (Arnold M. Washton). (MKA)

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approaches to drug abuse counseling

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ACKNOWLEDGMENTS

This publication contains information on various drug abuse counseling approaches, written by representatives of many well-known treatment programs. Although the counseling approaches included are used in some of the best known and most respected treatment programs in this country, it has not been determined whether all of these counseling models are equally effective. These various approaches are presented in an identical outline form so that the reader can compare and contrast the many treatment models described and learn more about the roles of the counselor and subject in a particular model.

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National Institute on Drug Abuse

Approaches to Drug Abuse Counseling

Introduction and Overview

John J. Boren, Lisa Simon Onken, and Kathleen M. Carroll

The consequences of drug and alcohol abuse in the United States are enormously costly. Although the costs can be evaluated in dollars, they are more readily understood in human terms: family discord, neglect of children, personal misery, financial straits, medical problems, fetal alcohol syndrome, HIV infection, legal problems, incarceration, automobile accidents, lower work productivity, and job lossÑand the list goes on. Combating and reducing the source of these problems have proven to be difficult indeed, but one of the most straightforward and noncontroversial ways is to provide effective treatment to drug abusers.

This book is about treatment. In particular, it is about the basic component of most treatment programsÑgroup and individual counseling. The intent of this book is to present information on various counseling approaches used in some of the best known and most respected treatment programs in the United States. Certainly all meritorious counseling models are not represented and, as a practical matter, could not be represented. However, chapters have been written by representatives of such well-known treatment programs as the Hazelden Foundation (chapter by Patricia Owen), the Betty Ford Center (by Fred Sipe), CENAPS® (by Terence T. Gorski), Living In Balance (by Jeffrey A. Hoffman), and the Washton Institute (by Arnold M. Washton). Other chapters were prepared by representatives of nationally known research centers on the treatment of drug abuse, including William R. Miller (University of New Mexico), Delinda Mercer (University of Pennsylvania), and Dennis C. Daley (Western Psychiatric Institute and Clinic). Two of the three treatments in Project Match, the monumental clinical trial sponsored by the National Institute on Alcohol Abuse and Alcoholism, are described in this volume. (See William R. MillerÕs Motivational Enhancement Therapy and Joseph NowinskiÕs Twelve-Step Facilitation.) Finally, chapters prepared by Elizabeth Driscoll Jorgensen and Richard Salwen and by Scott D. Miller illustrate innovative counseling strategies designed for special populations and settings. Each chapter was written by an authoritative spokesperson for the counseling model being described.

After surveying a number of chapters in a typical edited book on treatment models, the reader may have a difficult time comparing them, seeing how they are similar, seeing where they differ. Each author typically finds different topics important, emphasizes different issues, and writes a chapter whose coverage is unlike any other authorÕs. Furthermore, if the chapter focuses on the theoretical background, it may be hard to gain a practical understanding of the counseling interventions and what the counselor actually does with the client. In an effort to make the comparison of the various models less difficult and to clarify how the model is applied in practice, two of the editors (K.M.C. and L.S.O.) designed a comprehensive outline of topics that could be applied to almost any counseling approach. The topics ranged from theoretical rationale to specific counseling practices. The authors were asked to follow a specific format, and they did so, with only an occasional exception in a few chapters. The format is:

1. OVERVIEW, DESCRIPTION, AND RATIONALE
    - 1.1 General Description of Approach
    - 1.2 Goals and Objectives of Approach
    - 1.3 Theoretical Rationale/Mechanism of Action
    - 1.4 Agent of Change (e.g., patient, therapist, group affiliation)
    - 1.5 Conception of Drug Abuse/Addiction, Causative Factors

2. CONTRAST TO OTHER COUNSELING APPROACHES
    - 2.1 Most Similar Counseling Approaches
    - 2.2 Most Dissimilar Counseling Approaches

3. FORMAT
    - 3.1 Modalities of Treatment
    - 3.2 Ideal Treatment Setting (inpatient, outpatient, residential, other)
    - 3.3 Duration of Treatment (fixed or open ended; length and usual number of sessions)
    - 3.4 Compatibility With Other Treatments (e.g., pharmacotherapy, family therapy)
    - 3.5 Role of Self-Help Programs

4. COUNSELOR CHARACTERISTICS AND TRAINING
    - 4.1 Educational Requirements
    - 4.2 Training, Credentials, and Experience Required
    - 4.3 CounselorÕs Recovery Status (essential, helpful, irrelevant)
    - 4.4 Ideal Personal Characteristics of Counselor
    - 4.5 CounselorÕs Behaviors Prescribed
    - 4.6 CounselorÕs Behaviors Proscribed (techniques and interventions that are discouraged or contraindicated)
    - 4.7 Recommended Supervision (e.g., role, format, goals)

5. CLIENT-COUNSELOR RELATIONSHIP
    - 5.1 What Is the Counselor's Role? (teacher, collaborator, therapist, peer, adviser)
    - 5.2 Who Talks More?
    - 5.3 How Directive Is the Counselor?
    - 5.4 Therapeutic Alliance (the quality desired, strategies the counselor uses to build the alliance, strategies to address a poor alliance)

6. TARGET POPULATIONS
    - 6.1 Clients Best Suited for This Counseling Approach
    - 6.2 Clients Poorly Suited for This Counseling Approach

7. ASSESSMENT (before, during, or after treatment; major domains assessed; instruments typically used)

8. SESSION FORMAT AND CONTENT
    - 8.1 Format for a Typical Session (How does the session begin and end?)
    - 8.2 Several Typical Session Topics or Themes (Is the theme of the session determined by the patient or the counselor?)
    - 8.3 Session Structure
    - 8.4 Strategies for Dealing With Common Clinical Problems (lateness, missed sessions, patients who attend under the influence)
    - 8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

8.6 Strategies for Dealing With Crises
8.7 Counselor's Response to Slips and Relapses

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT (Are other family members involved and in what way?)

With all chapters following the format, the reader can not only compare the various counseling models on any selected characteristic but also have a better idea of what a counselor actually does while following a particular model.

The work for this book began in October 1993 when the Treatment Research Branch of the National Institute on Drug Abuse (NIDA) held a conference in Rockville, MD, on counseling models. Many of the authors represented in this volume attended this conference, described their counseling approaches, and exchanged views. Subsequently, chapters were prepared and then updated in the summer of 1996. The editors hope that the chapters will show how well-developed treatment programs counsel drug abusers and will serve as a resource to counselors, treatment providers, and interested readers who seek knowledge on counseling theory and practice.

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Dual Disorders Recovery Counseling

Dennis C. Daley

1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

Dual disorders recovery counseling (DDRC) is an integrated approach to treatment of patients with drug use disorders and comorbid psychiatric disorders. The DDRC model, which integrates individual and group addiction counseling approaches with psychiatric interventions, attempts to balance the focus of treatment so that both the patient's addiction and psychiatric issues are addressed.

The DDRC model is based on the assumption that there are several treatment phases that patients may go through. These phases are rough guidelines delineating some typical issues patients deal with and include:

Phase 1—Engagement and Stabilization. In this phase, patients are persuaded, motivated, or involuntarily committed to treatment. The main goal of this phase is to help stabilize the acute symptoms of the psychiatric illness and/or the drug use disorder. Another important goal is to motivate patients to continue in treatment once the acute crisis is stabilized or the involuntary commitment expires. Dealing with ambivalence regarding recovery, working through denial of either or both illnesses, and becoming motivated for continued care are other important goals during this phase.

This phase usually takes several weeks, but for some patients it takes longer to become engaged in recovery and to stabilize from acute effects of their dual disorders.

Phase 2—Early Recovery. This phase involves learning to cope with desires to use chemicals; avoiding or coping with people, places, and things that represent high-risk addiction relapse factors; learning to cope with psychiatric symptoms; getting involved in support groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), Rational Recovery (RR), Dual Recovery Anonymous, or mental health support groups; getting the family involved (if indicated); beginning to build structure into life; and identifying problems to work on in recovery.

This phase roughly involves the first 3 months following stabilization. However, some patients take much longer in this phase because they do not comply with treatment, continue to abuse drugs, experience exacerbations of psychiatric symptomology, or experience serious psychosocial problems or crises.

Phase 3—Middle Recovery. In this phase, patients continue working on issues from the previous phase as needed. In addition, patients learn to develop or improve coping skills to deal with intrapersonal and interpersonal issues. Examples of intrapersonal skills include coping with negative affect (anger, depression, emptiness, anxiety) and coping with maladaptive beliefs or thinking. Interpersonal issues that may be addressed during this phase include making amends, improving communication or relationship skills, and further developing social and recovery support systems. This phase also focuses on helping patients cope with persistent symptoms of psychiatric illness; drug use lapses, relapses, or setbacks; and crises related to the psychiatric disorder. It also focuses on helping identify and manage relapse warning signs and high-risk relapse factors related to either illness.

The middle recovery phase involves months 4 through 12, although some patients never get much beyond early recovery even after a long time in treatment. Patients who are treated for an initial acute episode of psychiatric illness with pharmacotherapy in addition to DDRC and who do not have a recurrent or persistent mental illness may be tapered off medications during this phase. Patients are usually not tapered off medications until they have several months or longer of significant improvement in psychiatric symptomology.

Phase 4—Late Recovery. This phase, also referred to as the "maintenance phase" of recovery, involves continued work on issues addressed in the middle phase of recovery and work on other clinical issues that emerge. Important intrapersonal or interpersonal issues may be explored in greater depth during this phase for patients who have continued abstinence and remained relatively free of major psychiatric symptoms.

This phase continues beyond year 1. Many patients with chronic or persistent forms of psychiatric illness (e.g., schizophrenia, bipolar disease, recurrent major depression), or severe personality disorders such as borderline personality disorder, often continue active involvement in treatment. Treatment during this phase may involve maintenance pharmacotherapy, supportive DDRC counseling, or some specific form of psychotherapy (e.g., interpersonal psychotherapy). Involvement in support groups continues during this phase of recovery as well.

1.2 Goals and Objectives of Approach

The goals of this counseling model are:

1. Achieving and maintaining abstinence from alcohol or other drugs of abuse or, for patients unable or unwilling to work toward total abstinence, reducing the amount and frequency of use and concomitant biopsychosocial sequelae associated with drug use disorders.

2. Stabilizing acute psychiatric symptoms.

3. Resolving or reducing problems and improving physical, emotional, social, family, interpersonal, occupational, academic, spiritual, financial, and legal functioning.

4. Working toward positive lifestyle change.

5. Early intervention in the process of relapse to either the addiction or the psychiatric disorder.

1.3 Theoretical Rationale/Mechanism of Action

The DDRC counseling approach involves a broad range of interventions:

1. Motivating patients to seek detoxification or inpatient treatment if symptoms warrant, and sometimes facilitating an involuntary commitment for psychiatric care.

2. Educating patients about psychiatric illness, addictive illness, treatment, and the recovery process.

3. Supporting patients' efforts at recovery and providing a sense of hope regarding positive change.

4. Referring patients for other needed services (case management, medical, social, vocational, economic needs).

5. Helping patients increase self-awareness so that information regarding dual disorders can be personalized.

6. Helping patients identify problems and areas of change.

7. Helping patients develop and improve problemsolving ability and develop recovery coping skills.

8. Facilitating pharmacotherapy evaluation and compliance. (This requires close collaboration with the team psychiatrist.)

1.4 Agent of Change

The DDRC model assumes that change may occur as a result of the patient-counselor relationship and the team relationship (i.e., counselor, psychiatrist, psychologist, nurse, or other professionals such as case manager or family therapist). A positive therapeutic alliance is seen as critical in helping patients become involved and stay involved in the recovery process. Community support systems, professional treatment groups, and self-help programs also serve as possible agents of positive change for dually diagnosed patients. For the more chronically and persistently mentally ill patients, a case manager may also function as an important agent in the change process.

Although patients have to work on a number of intrapersonal and interpersonal issues as part of long-term recovery, medications can facilitate this process by attenuating acute symptoms, improving mood, or improving cognitive abilities or impulse control. Thus, medications may eliminate or reduce symptoms as well as help patients become more able to address problems during counseling sessions. A severely depressed patient may be unable to focus on learning cognitive or behavioral interventions until he or she experiences a certain degree of remission from symptoms of depression; a floridly psychotic patient will not be able to focus on abstinence from drugs until the psychotic symptoms are under control.

1.5 Conception of Drug Abuse/ Addiction, Causative Factors

Both psychiatric and addictive illnesses are viewed as biopsychosocial disorders. These disorders or diseases are caused or maintained by a variety of biological, psychological, and cultural/social factors. The degree of influence of specific factors may vary among psychiatric disorders.

This DDRC model assumes that there are several possible relationships between psychiatric illness and addiction (Daley et al. 1993; Meyer 1986).

1. Axis I and Axis II psychopathology may serve as a risk factor for addictive disorders (e.g., the odds of having an addictive disorder among individuals with a mental illness is 2.7 according to the National Institute of Mental Health's Epidemiologic Catchment Area [ECA] survey).

2. Some psychiatric patients may be more vulnerable than others to the adverse effects of alcohol or other drugs.

3. Addiction may serve as a risk factor for psychiatric illness (e.g., the odds of having a psychiatric disorder among those with a drug use disorder is 4.5 according to the ECA survey).

4. The use of drugs can precipitate an underlying psychiatric condition (e.g., PCP or cocaine use may trigger a first manic episode in a vulnerable individual).

5. Psychopathology may modify the course of an addictive disorder in terms of:

    a. Rapidity of course (earlier age depressives experience addiction problems earlier; male-limited alcoholics [25 percent] with antisocial behaviors have earlier onset of addiction compared with milieu-limited alcoholics [Cloninger 1987]).

    b. Response to treatment (patients with antisocial or borderline personality disorder often drop out of treatment early).

    c. Symptom picture and long-term outcome (high psychiatric severity patients as measured by the Addiction Severity Index (ASI) do worse than low psychiatric severity patients; there is a strong association between relapse and psychiatric impairment among opiate addicts and some association between relapse and psychiatric impairment among alcoholics [Catalano et al. 1988; McLellan et al. 1985]).

6. Psychiatric symptoms may develop in the course of chronic intoxications (e.g., psychosis may follow PCP use or chronic stimulant use; suicidal tendencies and depression may follow a cocaine crash).

7. Psychiatric symptoms may emerge as a consequence of chronic use of drugs or a relapse (e.g., depression may be caused by an awareness of the losses associated with addiction; depression may follow a drug or alcohol relapse).

8. Drug-using behavior and psychopathological symptoms (whether antecedent or consequent) will become meaningfully linked over the course of time.

9. The addictive disorder and the psychiatric disorder can develop at different points in time and not be linked (e.g., a bipolar patient may become hooked on drugs years after being stable from a manic disorder; an alcoholic may develop panic disorder or major depression long after being sober).

10. Symptoms of one disorder can contribute to relapse of the other disorder (e.g., increased anxiety or hallucinations may lead the patient to alcohol or other drug use to ameliorate symptoms; a cocaine or alcohol binge may lead to depressive symptoms).

2. CONTRAST TO OTHER COUNSELING APPROACHES

2.1 Most Similar Counseling Approaches

The DDRC model is most similar to various aspects of several models of treatment used in addiction counseling, mental health counseling, or both. These include individual and group addiction recovery models, the psychoeducational (PE) model, the relapse prevention (RP) model, the cognitive-behavioral model, and the interpersonal model.

2.2 Most Dissimilar Counseling Approaches

The DDRC model is dissimilar to the various forms of dynamic therapies.

3. FORMAT

3.1 Modalities of Treatment

The DDRC model can be used in a variety of group treatments and in individual treatment. It can also be adapted to family treatment.

3.2 Ideal Treatment Setting

The DDRC model was primarily developed for use in a mental health or dual disorders treatment setting. It can be used throughout the continuum of care in inpatient, other residential, partial hospital, and outpatient settings. The specific areas of focus will depend on each patient's presenting problems and symptoms and the treatment setting. Certain aspects of this model could be adapted and used in addiction treatment settings provided that appropriate training, supervision, and consultation are available for the counselor.

3.3 Duration of Treatment

Acute inpatient dual-diagnosis treatment usually lasts up to 3 weeks. Longer term specialty residential treatment programs may last from several months to a year or more. Partial hospitalization programs usually last from 6 to 12 months. Outpatient treatment lasts 6 months or longer. Recurrent conditions, such as certain depressive disorders and bipolar illness, as well as persistent mental illness such as schizophrenia, typically require ongoing participation in maintenance pharmacotherapy and some type of supportive counseling.

3.4 Compatibility With Other Treatments

The DDRC model is very compatible with pharmacotherapy and family treatment. Many patients require medication to treat psychiatric symptoms. Therefore, medication compliance, the perception of taking medications as a recovering alcoholic or addict, and potential adverse effects of alcohol or other drugs on medication efficacy are important issues to discuss with the patient. Family participation in assessment and treatment is viewed as important and compatible with the DDRC model. The family can:

1. Help provide important information in the assessment process.
2. Provide support to the recovering patient.
3. Address their own questions, concerns, and reactions to coping with the dually diagnosed patient.
4. Address their own problems and issues in treatment sessions or self-help programs.
5. Help identify early signs of addiction relapse or psychiatric recurrence and point these out to the recovering dually diagnosed family member.

A combination of family PE programs, family counseling sessions, and family support programs can be used to help families. Referrals for assessment of serious problems (psychiatric, drug abuse, behavioral) among specific family members can also be initiated as necessary (e.g., a child of a patient who is suicidal, very depressed, or getting into trouble at school can be referred for a psychiatric evaluation).

3.5 Role of Self-Help Programs

Self-help programs are very important in the DDRC model of treatment. All patients are educated regarding self-help programs and linked up to specific programs. The self-help programs recommended may include any of the following for a given patient: AA, NA, CA, and other addiction support groups such as RR or Women for Sobriety; dual-recovery support groups; and mental health support groups. However, this model does not assume that a patient cannot recover without involvement in a 12-step group or that failure to attend 12-step groups is a sign of resistance. The DDRC model also assumes that some patients may use some of the tools of recovery of self-help programs even if they do not attend meetings. Sponsorship, recovery literature, slogans, and recovery clubs are also seen as very helpful aspects of recovery for dually diagnosed patients.

4. COUNSELOR CHARACTERISTICS AND TRAINING

4.1 Educational Requirements

The educational requirements are variable for inpatient staff and depend on the professional discipline's requirements. Formal education of inpatient staff include M.D., Ph.D., master's, bachelor's, and associate degrees. Training in fields such as nursing may vary as well and include M.S.N., B.S.N., R.N., and L.P.N. Outpatient therapists tend to have at least a master's degree or higher and function more autonomously than inpatient staff.

4.2 Training, Credentials, and Experience Required

To effectively provide counseling services to dually diagnosed patients, the counselor needs to have a broad knowledge of assessment and treatment of dual disorders. Specific areas with which the counselor should be familiar, at a minimum, include the following:

1. Psychiatric illnesses (types, causes, symptoms, and effects).

2. Drug use disorders (trends in drug abuse; types and effects of various drugs; causes, symptoms, and effects of addiction).

3. The relationship between the psychiatric illness and drug use.

4. The recovery process for dual disorders.

5. Self-help programs (for addiction, mental health disorders, and dual disorders).

6. Family issues in treatment and recovery.

7. Relapse (precipitants, warning signs, and RP strategies for both disorders).
8. Specialized psychosocial treatment approaches for various psychiatric disorders (e.g., treatments for posttraumatic stress disorder, obsessive-compulsive disorder).

9. Pharmacotherapy.

10. The continuum of care (for both addiction and psychiatric illnesses).

11. Local community resources.

12. The process of involuntary hospitalization.

13. Motivational counseling strategies.

14. Ways to deal with ambivalent patients and those who do not want help.

15. Strategies to deal with refractory or treatment-resistant patients with chronic forms of mental illness.

16. How to use bibliotherapeutic assignments to facilitate the patient's recovery.

The counselor must be able to develop a therapeutic alliance with a broad range of patients who manifest many different disorders and differing abilities to utilize professional treatment. This requires awareness of the counselor's own issues, biases, limitations, and strengths, as well as the counselor's willingness to examine his or her own reactions to different patients.

The counselor needs to be able to effectively network with other service providers since many of these dually diagnosed patients have multiple psychosocial needs and problems. Because crises often arise, the counselor must also be conversant with crisis intervention approaches. The ability to work with a team is also essential in all treatment contexts.

Experience with addicts and mental health patients is the ideal. However, if a counselor is trained in one field and has access to additional training and supervision in another, it is possible to expand knowledge and skills and work effectively with dually diagnosed patients.

4.3 Counselor's Recovery Status

If a counselor has the training, knowledge, and experiential background in working with psychiatric patients and with addicts, a personal history of recovery can be helpful. Although self-disclosure is sometimes appropriate, in general, the counselor providing treatment should share less of his or her own recovery experience than is typically shared in the more traditional addiction counseling model.

4.4 Ideal Personal Characteristics of Counselor

Hope and optimism for the patient's recovery; a high degree of empathy, patience, and tolerance; flexibility; an ability to enjoy working with difficult patients; a realistic perspective on change and steps toward success; a low need to control the patient; an ability to engage the patient yet be able to detach; and an ability to utilize a multiplicity of treatment interventions rather than relying on a single way of counseling are important characteristics and qualities that counselors need.

4.5 Counselor's Behaviors Prescribed

The DDRC approach requires a broad range of behaviors on the part of the counselor. Specific behaviors are mediated by the severity of the patient's symptoms and his or her related needs and problems. The counselor's behaviors may include any of the following:

1. Providing information and education.
2. Challenging denial and self-destructive behaviors. (Confrontation is modified to take into account the patient's ego strength and ability to tolerate confrontation.)
3. Providing realistic feedback on problems and progress in treatment.
4. Encouraging and monitoring abstinence.
5. Helping the patient get involved in self-help groups.
6. Helping the patient identify, prioritize, and work on problems and recovery issues.
7. Monitoring addiction recovery issues.
8. Monitoring target psychiatric symptoms (suicidality, mood symptoms, thought disorder symptoms, or problem behaviors).
9. Helping the patient develop specific RP skills (e.g., coping with alcohol or other drug cravings, refusing offers to get high, challenging faulty thinking, coping with negative affect, improving interpersonal behaviors, managing relapse warning signs).
10. Advocating on behalf of the patient and facilitating inpatient admission when needed.
11. Facilitating the use of community resources or services.
12. Developing therapeutic assignments aimed at helping the patient reach a goal or make a specific change.
13. Following up when a patient fails to follow through with treatment.

14. Offering support, encouragement, and outreach.

4.6 Counselor's Behaviors Proscribed

The DDRC counselor does not typically interpret the patient's behaviors or motivation. The focus is more on understanding and coping with practical issues related to the dual disorders and current functioning. The counselor avoids extensive exploration of past traumas during the early phase of recovery because this can lead to avoidance of addressing the drug use disorder and can increase the patient's anxiety. The DDRC counselor also minimizes time spent on coaddiction issues since this can deflect from the drug use problem and raise anxiety.

Harsh confrontation is avoided because it can adversely impact on the patient's sense of self and can drive the patient away from treatment. Confrontation can be used, but it should be done in a caring, nonjudgmental, nonpunitive, and reality-oriented manner.

4.7 Recommended Supervision

The goals of supervision are to help the counselor:

1. Increase knowledge of dual disorders counseling.

2. Improve special counseling skills.

3. Deal with personal issues or reactions that impede therapeutic alliance or progress (e.g., anger toward a patient who relapses, negative reactions to a patient with a personality disorder).

4. Use personal strengths in the counseling process (e.g., personal experiences, humor).

5. Maintain a reasonable therapeutic focus on the patient's addiction and mental health disorder.

6. Determine strategies to work through impasses in counseling.

A variety of formats can be used in supervising the DDRC approach:

1. Joint discussion of individual counseling cases, family sessions, or group sessions.

2. Review of clinical notes and treatment plans.

3. Live observation of counseling sessions.

4. Review and discussion of audiotapes or videotapes of counseling sessions.

5. Cotherapy sessions.

6. Group supervision with other counselors in which individual, family, or groups are reviewed or in which clinical concerns are shared and explored.

One of the most helpful but time-intensive formats is where the counselor can be "seen in action." This provides tremendous opportunities to identify personal or professional areas that need further attention. This is especially helpful to less experienced counselors. Once a counselor works through anxiety about being scrutinized, he or she usually finds this process helpful.

Counselors should receive specific feedback regarding their counseling. This includes positive reinforcement for good work as well as critical feedback on areas of weakness. For example, a group counselor can benefit from feedback pointing out that he or she talks too much in the group sessions or tells patients how to cope with a recovery issue before eliciting their ideas on coping strategies.

The use of adherence scales in some clinical research protocols is an excellent way of providing specific feedback on a particular treatment session. The counselor is rated on the performance of specific interventions as well as the quality of those interventions. The major drawback is that tapes of specific treatment sessions have to be reviewed in detail, a time-consuming process.

5. CLIENT-COUNSELOR RELATIONSHIP

5.1 What Is the Counselor's Role?

As evidenced by the list of counselor behaviors noted earlier, many roles are assumed in DDRC: educator, collaborator, adviser, advocate, and problemsolver.

5.2 Who Talks More?

Generally, the patient talks the most during individual DDRC sessions. In PE groups, the counselor is usually very active in providing education to the group. However, patients are encouraged to ask questions, share personal experiences related to the group topic, and express feelings.

5.3 How Directive Is the Counselor?

In DDRC, the counselor may be very directive and active with one patient and less directive and active with another. The approach must be individualized and take into account each patient's strengths, abilities, and deficits. However, the counselor is generally more directive than in traditional mental health counseling, particularly in relation to continued drug use and relapse setups and in pointing out other self-defeating behavior patterns.

5.4 Therapeutic Alliance

A good therapeutic alliance (TA) facilitates recovery and is based on the counselor's ability to connect with the patient, respect differences, show empathy, use humor, and understand the inner world of the patient. Listening, providing information, being supportive and encouraging, and being up front and directive can help build the TA.

A poor TA often shows in a patient's missed appointments or failure to comply with treatment. Discussing common problems in recovery and acknowledging specific problems between the counselor and the patient can help improve a poor alliance. Calling patients who drop out of treatment early and inquiring as to whether they think a new treatment plan can help may also help correct a poor TA. Discussing specific cases in supervision can help the counselor identify causes of a poor TA and develop strategies to correct the problem. As a last resort, a case may be transferred to another counselor if the client-counselor relationship is such that a TA cannot be formed.

6. TARGET POPULATIONS

6.1 Clients Best Suited for This Counseling Approach

The DDRC approach can be adapted for virtually any type of addiction, mental health disorder, or combination of dual disorders. However, it is best suited for mood, anxiety, schizophrenic, personality, adjustment, and other addictive disorders, in combination with alcohol or other drug addiction.

6.2 Clients Poorly Suited for This Counseling Approach

Clients with mental retardation, organic brain syndromes, head injuries, and more severe forms of thought disorders are less suited for this counseling approach.

7. ASSESSMENT

The initial assessment involves a combination of the following: psychiatric evaluation, mental status exam, ASI, physical examination, laboratory work, and urinalysis. Patient and collateral interviews and review of previous records are part of the assessment process. The assessment process for inpatient treatment is more extensive and involved than assessment for outpatient care.

An assessment covers the following areas: review of current problems, symptoms and reasons for referral, current and past psychiatric history, current and past drug use and abuse, history of treatment, mental status exam, medical history, family history, developmental history (e.g., development, school, work), current stressors, social support system, current and past suicidality, current and past aggressiveness or homicidality, and other areas based on the judgment of the evaluation team (e.g., relapse history, patterns of hospitalization).

The drug abuse history should include specific drugs used (past and present), patterns of use (frequency, quantity, methods), context of use, and consequence of use (medical, psychiatric, family, legal, occupational, spiritual, financial). It should also include review of drug abuse or addiction symptoms (e.g., loss of control, obsession or preoccupation, tolerance changes, inability to abstain despite repeated attempts, withdrawal syndromes, continuation of use despite psychosocial problems, impairment caused by intoxications). Clinical interviews can be used as well as specific assessment instruments, such as the ASI, Drug Use Screening Inventory, Drug Abuse Screening Test, Milligan Alcoholism Screening Test, or other addiction-specific instruments. Regular or random urinalysis or breathalyzers can be used to monitor drug use, particularly in the early phases of recovery.

Specific instruments may also be used for psychiatric disorders to obtain objective and subjective data. These may be administered by a professional (e.g., certain personality disorder interviews), or they may be completed by the patient at different points in time (e.g., Beck Depression or Anxiety Inventories, Zung Depression Inventory). These can also be used to gather baseline data and measure change in symptoms over time.

Completing recovery workbook assignments or the drug abuse problem checklist (see Appendix for examples) is an additional way of assessing a patient's perception of his or her problem areas related to drug use. The counselor can use these tools to identify specific areas for focus in individual DDRC sessions.

8. SESSION FORMAT AND CONTENT

8.1 Format for a Typical Session

An individual DDRC session reviews addiction and mental health recovery issues. The time spent in a given session on addiction or mental health issues varies and depends on the specific issues and recovery status of a particular patient. For example, even if a depressed alcoholic patient were sober 9 months, the counselor may briefly inquire about any number of addiction recovery issues (e.g., cravings or close calls, actual episodes of use, involvement in self-help group meetings, discussions with sponsors). Or, if an addicted patient's depression were improved, the counselor would inquire about the typical symptoms this patient had prior to coming to treatment (e.g., mood, suicidality, energy). Any crisis issues would be attended to as well.

The majority of time spent during the individual counseling session (unless a crisis takes up the session) focuses on the patient's agenda. The patient is usually asked at the beginning of the session what concern or problem he or she wants to focus on in that day's session. The problem or concern should be one that the patient has identified as an important part of his or her treatment plan. In relation to the problem or issues identified, the counselor helps the patient explore this to better understand and cope with it. Coping strategies are especially important since the session should be a purposeful one aimed at helping the patient work toward change. During the course of the DDRC session, any "live" material that is relevant to the patient's dual disorders or recovery can be processed. For example, if the patient gives evidence of maladaptive thinking in the session that is contributing to anxiety or depressive symptoms (jumping to conclusions or focusing only on the negative), this can be pointed out and discussed in the context of the patient's problems.

The DDRC session ends with a review of what the patient will be doing between this and the next session relating to his or her recovery. It is helpful for the counselor to provide encouragement and positive feedback at the end of each session for the work that the patient accomplished and for the effort put forth. Reading, writing, or behavioral assignments may be given at the end of the session. The goal of these therapeutic assignments is to have the patient actively work on problems and issues between counseling sessions.

8.2 Several Typical Session Topics or Themes

Medication visits and special consultations are held with the counselor and psychiatrist. These ensure integrated care, help prevent the patient from "splitting" the counselor and psychiatrist, and enhance ongoing team communication. These visits are usually brief and focus on medication issues or treatment compliance issues. The counselor gives the psychiatrist an update on treatment prior to the joint meeting. The counselor adds input during the session as needed. The psychiatrist and counselor can strategize after the meeting regarding therapeutic interventions.

8.3 Session Structure

PE group sessions can easily be adapted to inpatient, residential, partial hospital, or outpatient settings. A specific PE group treatment curriculum can be developed for use in any treatment setting. PE group programs can vary in terms of number of sessions offered per week and total number of sessions offered during the treatment course. For example, patients in the author's various inpatient dual disorders programs participate in up to five PE groups each week. Outpatients may attend weekly PE groups for up to several months.

PE groups provide information on important recovery topics to patients and help them begin to explore different coping strategies to handle the various demands of recovery. It is important to try to balance the focus on problems and coping strategies so that patients can begin to be exposed to positive strategies that can help them deal with their issues and problems.

PE group sessions are structured around a specific recovery issue or theme. The specific themes reviewed depend on the total number of sessions available for the patient. Each PE group is structured as follows (see Appendix for sample group sessions):

1. Topic or recovery theme.

2. Objectives or purpose of PE group session.

3. Major points to review and methods of covering the material.

4. PE group handouts to be read aloud, completed, and discussed in group, allowing members to relate personally to the PE topic.

The group leader reviews the material interactively, so that patients can ask questions, share personal experiences related to the material covered, and provide help and support to one another. Outpatient and partial hospital PE group sessions usually last 1½ hours; inpatient PE group sessions usually last 1 hour.

Prior to reviewing the PE group topic material in outpatient groups, the leader first takes time to discuss whether or not any patients have had setbacks, lapses or relapses, close calls, strong cravings to use drugs, or any other pressing issue since the last session. Some time is spent discussing these matters prior to reviewing the group curriculum.

Specific topics or recovery themes explored in PE groups include:

1. Understanding psychiatric illnesses (causes, symptoms, and treatment) and addiction (causes, symptoms, and treatment).
2. Understanding relationships between drug use and psychiatric disorders.
3. Denial of dual disorders and common roadblocks in recovery.
4. Medical and psychiatric effects of drugs and addiction.
5. Psychosocial effects of dual disorders.
6. The recovery process for dual disorders.
7. Medication education.
8. Coping with cravings and desires to use alcohol or other drugs.
9. Coping with anger, anxiety, and worry.
10. Coping with boredom.
11. Discovering ways to use leisure time.
12. Coping with depression.
13. Coping with guilt and shame.
14. Family issues (e.g., impact of dual disorders, recovery resources, family treatment).
15. Developing a sober recovery support system.
16. Coping with pressures to get high or to stop taking psychiatric medications.
17. Changing negative or maladaptive thinking.
18. Spirituality in recovery.
19. Joining AA/NA/CA, mental health, and dual recovery support groups and recovery clubs.
20. Recovery prevention (warning signs, high-risk factors).
21. Followup inpatient care.
22. Understanding and using psychotherapy and counseling.

This material can also be modified and adapted for use in 90-minute weekly multiple family groups (MFGs) or for use in monthly, daily, or halfday PE workshops attended by patients and families or significant others (SOs).

Any of the above themes as well as others may be explored in individual DDRC sessions.

8.4 Strategies for Dealing With Common Clinical Problems

Lateness is discussed directly with the patient to determine the reasons for it, and strategies are discussed so the patient can better comply with the treatment schedule. Chronic patterns of lateness may be generalized as indicative of broader patterns of difficulty with responsibility or as part of a self-defeating pattern of behavior.

Missed sessions are discussed with the patient to determine why and to work through any resistance the patient has. A patient who fails to show or who calls to cancel an appointment is usually called by the clinician or sent a friendly note in the mail offering another appointment or asking the patient to call so an appointment can be rescheduled.

Interventions with patients who come to sessions under the influence are dealt with in a number of different ways depending on their condition.

Detoxification and inpatient hospitalization may be arranged in severe cases involving potential withdrawal and florid psychiatric symptoms. In other cases, crisis intervention may be offered or the patient may be helped to make arrangements to go home and return for another appointment when not under the influence of chemicals. Generally, these situations are handled in the most appropriate clinical manner. Limits may be set without coming across as punitive or judgmental.

Contracts noting a patient's specific issues (lateness, missed sessions, failure to complete therapeutic assignments, coming to sessions under the influence of chemicals) may also be created.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

Treatment sessions deal with ambivalence of patients regarding ongoing participation in treatment. The counselor attempts to normalize and validate ambivalence or denial in the context of addiction or psychiatric illness. Education, support, the use of therapeutic assignments, sessions with the team to discuss symptoms and behaviors of the patient, and sessions involving collaterals such as family or SOs may be used to help deal with denial and resistance. Generally, any resistance is "grist for the therapeutic mill" and is explored in treatment sessions.

Poor motivation is usually seen as a manifestation of illness, particularly with more severely addicted or psychiatrically impaired patients. Personality issues also greatly contribute to resistance and poor motivation.

8.6 Strategies for Dealing With Crises

A very flexible approach is needed in dealing with crisis since dually diagnosed patients often experience exacerbations of illness. In more severe cases, voluntary or involuntary hospitalization may be sought to help stabilize a patient. Additional face-to-face sessions with any member(s) of the treatment team, including the case manager for persistently mentally ill patients, may also be held. In some instances, supportive sessions via telephone are conducted. All patients are given an emergency phone number that can be called 24 hours a day, 7 days a week, and all patients are instructed on how and when to use the psychiatric emergency room.

8.7 Counselor's Response to Slips and Relapses

The counselor typically approaches lapses or relapses as opportunities for the patient to learn about relapse precipitants or setups. All lapses and relapses to drug use are explored in an attempt to identify warning signs. Strategies are discussed to help the patient better prepare for recovery. Additional sessions or telephone contacts may be used to help the patient stabilize from some relapses. Inpatient detoxification or rehabilitation programs may be arranged in instances where the relapse is severe and cannot be interrupted with the help and support of counseling along with self-help programs (e.g., AA, NA, CA).

Drug use relapses are processed in terms of their impact on psychiatric symptoms and recovery from dual disorders. If a patient is on medication, the possible interactions with alcohol or nonprescribed drugs are discussed.

Psychiatric relapses are discussed in terms of warning signs and causes to help the patient determine what may have contributed to the relapse. Additional sessions with the counselor or other members of the treatment team may be provided to help the patient stabilize. Medication adjustments also may be made, depending on the symptoms experienced by the patient.

When psychiatric symptoms are life threatening or cause significant impairment in functioning, an inpatient hospitalization may be arranged.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

Families are often adversely affected by a patient with dual disorders and have many questions and concerns regarding their ill member. Family members can have a significant impact on the patient and can be either an excellent source of support or an additional stress during the patient's recovery. Counselors are encouraged to include families in assessment and treatment sessions. PE programs, MFGs, and individual family sessions may be used. Patients in need of family therapy may be referred to a social worker or therapist conversant with family therapy approaches if the DDRC counselor is not familiar with family therapy. Particular attention is paid to children of patients so that assessments can be arranged if a counselor feels that a psychiatric evaluation is warranted for a patient's child.

PE programs provide helpful information on dual disorders and recovery and encourage families to attend support groups for mental health disorders or addictive disorders (e.g., Nar-Anon or Al-Anon). MFGs that include the patient and his or her family members and that combine open discussion with some focus on acquiring education can be offered on a weekly or monthly basis. Mutual help and support can be shared among members of different families. Individual family sessions can be used to focus on specific issues and problems of a particular family.

The counselor also works with the patient on strategies to improve communication and relationships with family members even when they are not directly involved in treatment sessions or recovery group meetings.

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APPENDIX. A SAMPLE DUAL RECOVERY-PSYCHOEDUCATIONAL GROUP

RELAPSE PREVENTION: AFTERCARE PLANNING/COPING WITH EMERGENCIES

Objectives

1. Teach patients the importance of having a followup aftercare plan to facilitate ongoing recovery. This plan should involve professional treatment and participation in self-help support programs (e.g., AA or NA) and mental health consumer groups.

2. Teach patients that failure to comply with ongoing treatment increases the chances of chemical use or psychiatric relapse.

3. Help patients identify potential benefits of continued involvement in treatment and recovery.

4. Teach patients the importance of being prepared to handle emergencies (i.e., a return to chemical use or a return or worsening of psychiatric symptoms).

Methods

1. Use a lecture/discussion format. Write the major points on the board for reinforcement.

2. State that studies and clinical experience show that patients who continue in treatment after discharge from the hospital do better than those who do not. Failure to comply often contributes to relapse.

3. Stress the importance of taking medications even after symptoms are under control.

4. Ask patients who have failed to comply with treatment in the past, and those who did, to state how this affected their addiction and psychiatric disorder.

5. Have patients list potential benefits of complying with treatment.
6. Ask patients what they could do if they felt their treatment plan was not working (i.e., instead of dropping out of treatment).

7. Ask patients to list steps they could take if they lapsed or relapsed to chemical use or their psychiatric symptoms returned or worsened.

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The CENAPS® Model of Relapse Prevention Therapy (CMRPT®)

Terence T. Gorski

1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

The CENAPS® Model of Relapse Prevention Therapy (CMRPT®) is a comprehensive method for preventing chemically dependent clients from returning to alcohol and other drug use after initial treatment and for early intervention should chemical use occur.

1.2 Goals and Objectives of Approach

The five primary goals of the CMRPT are to:

1. Assess the global lifestyle patterns contributing to relapse by completing a comprehensive self-assessment of life, addiction, and relapse history.

2. Construct a personalized list of relapse warning signs that lead the relapser from stable recovery back to chemical use.

3. Develop warning sign management strategies for the critical warning signs.

4. Develop a structured recovery program that will allow clients to identify and manage the critical warning signs as they occur.

5. Develop a relapse early intervention plan that will provide the client and significant others with step-by-step instructions to interrupt alcohol and other drug use should it recur.

1.3 Theoretical Rationale/Mechanism of Action

The CMRPT is a clinical procedure that integrates the disease model of chemical addiction and abstinence-based counseling methods with recent advances in cognitive, affective, behavioral, and social therapies. The method is designed to be delivered across levels of care with a primary focus on outpatient delivery systems. The CMRPT consists of five primary components:

1. Assessment.

2. Warning sign identification.

3. Warning sign management.

4. Recovery planning.

5. Relapse early intervention training.

Cognitive, affective, and behavioral therapy principles are targeted to accomplish the specific goals of each CMRPT component.

The CMRPT incorporates standard and structured group and individual therapy sessions and psychoeducational (PE) programs that focus primarily on these five primary goals. The treatment is holistic in nature and involves clients in a structured program of recovery activities. Willingness to comply with the recovery structure and actively participate within the structured sessions is a major factor in accepting clients for treatment with this model.

1.4 Agent of Change

The primary agent of change is the completion of a structured clinical protocol in a process-oriented interaction among the client, the primary therapist or counselor, and members of the therapy groups.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

The CMRPT has been under development since the early 1970s (Gorski 1989*a*). It integrates the fundamental principles of Alcoholics Anonymous (AA) with professional counseling and therapy to meet the needs of relapse-prone clients.

The CMRPT can be described as the third wave of chemical addiction treatment. The first wave was the introduction of the 12 steps of AA. The second wave was the integration of AA with professional treatment into a model known as the Minnesota Model. The CMRPT, the third wave in chemical addiction treatment, integrates knowledge of chemical addiction into a biopsychosocial model and 12-step principles with advanced cognitive, affective, behavioral, and social therapy principles to produce a model for both primary recovery and relapse prevention (RP).

The CMRPT is based on a biopsychosocial model, which states that chemical addiction is a primary disease or disorder resulting in abuse of and addiction to mood-altering chemicals. Long-term use of mood-altering chemicals causes brain dysfunction that disorganizes personality and causes social and occupational problems.

The CMRPT is based on the belief that total abstinence plus personality and lifestyle change are essential for full recovery. People raised in dysfunctional families often develop self-defeating personality styles (AA calls them character defects) that interfere with their ability to recover. Addiction is a chronic disease that has a tendency toward relapse. Relapse is the process of becoming dysfunctional in recovery, which ends in physical or emotional collapse, suicide, or self-medication with alcohol or other drugs. The CMRPT incorporates the roles of brain dysfunction, personality disorganization, social dysfunction, and family-of-origin problems to the problems of recovery and relapse.

Brain dysfunction occurs during periods of intoxication, short-term withdrawal, and long-term withdrawal. Clients with a genetic history of addiction appear to be more susceptible to this brain dysfunction. As the addiction progresses, the symptoms of this brain dysfunction cause difficulty in thinking clearly, managing feelings and emotions, remembering things, sleeping restfully, recognizing and managing stress, and psychomotor coordination. The symptoms are most severe during the first 6 to 18 months of sobriety, but there is a lifelong tendency of these symptoms to return during times of physical or psychosocial stress.

Personality disorganization occurs because the brain dysfunction interferes with normal thinking, feeling, and acting. Some of the personality disorganization is temporary and will spontaneously subside with abstinence as the brain recovers from the dysfunction. Other personality traits will become deeply habituated during the addiction and will require treatment to subside.

Social dysfunction, which includes family, work, legal, and financial problems, emerges as a consequence of brain dysfunction and resultant personality disorganization.

Addiction can be influenced, not caused, by self-defeating personality traits that result from being raised in a dysfunctional family. Personality is the habitual way of thinking, feeling, acting, and relating to others that develops in children and is unconsciously perpetuated in adult living. Personality develops as a result of an interaction between genetically inherited traits and family environment.

Being raised in a dysfunctional family can result in self-defeating personality traits or disorders. These traits and disorders do not cause the addiction to occur. They can cause a more rapid progression of the addiction, make it difficult to recognize and seek treatment during the early stages of the addiction, or make it difficult to benefit from treatment. Self-defeating personality traits and disorders also increase the risk of relapse. As a result, family-of-origin problems need to be appropriately addressed in treatment.

The relapse syndrome is an integral part of the addictive disease process. The disease is a double-edged sword with two cutting edges—drug-based symptoms that manifest themselves during active episodes of chemical use and sobriety-based symptoms that emerge during periods of abstinence. The sobriety-based symptoms create a tendency toward relapse that is part of the disease itself. Relapse is the process of becoming dysfunctional in sobriety because of sobriety-based symptoms that lead to renewed alcohol or other drug use, physical or emotional collapse, or suicide. The relapse process is marked by predictable and identifiable warning signs that begin long before alcohol and other drug use or collapse occurs. RP therapy teaches clients to recognize and manage these warning signs and to interrupt the relapse progression early and return to positive progress in recovery.

The CMRPT conceptualizes recovery as a developmental process that goes through six stages. The first stage is Transition, where clients recognize that they are experiencing alcohol- and other drug-related problems and need to pursue abstinence as a lifestyle goal so they can resolve these problems. The second stage is Stabilization, where clients recover from acute and postacute withdrawal and stabilize their psychosocial life crisis. The third stage is Early Recovery, where clients identify and learn how to replace addictive thoughts, feelings, and behaviors with sobriety-centered thoughts, feelings, and behaviors. The fourth stage is Middle Recovery, where clients repair the lifestyle damage caused by the addiction and develop a balanced and healthy lifestyle. The fifth stage is Late Recovery, where clients resolve family-of-origin issues that impair the quality of recovery and act as long-term relapse triggers. The sixth stage is Maintenance, where clients continue a program of growth and development and maintain an active recovery program to ensure that they do not slip back into old addictive patterns.

The CMRPT is based on a balanced biopsychosocial model that recognizes three primary psychological domains of functioning and three primary social domains of functioning. Each of these domains is considered equally important.

The primary psychological domains are:

1. Thinking.
2. Feeling.
3. Acting.

The primary social domains are:

1. Work.
2. Friendship.
3. Intimate relationships.

The clinical goal is to help clients achieve competent functioning within each of these domains.

Clients usually have a preference for one psychological domain and one social domain. These preferred domains become overdeveloped while the others remain underdeveloped. The goal is to reinforce the skills in the overdeveloped domains while focusing the client on building skills in the underdeveloped domains. The goal is to achieve healthy, balanced functioning.

Imagery is viewed as a primary mediating function between thinking, feeling, and acting. The CMRPT makes extensive use of both guided imagery for mental rehearsal and spontaneous imagery for cognitive and emotional integration work.

2. CONTRAST TO OTHER COUNSELING APPROACHES

2.1 Most Similar Counseling Approaches

The CMRPT is an applied cognitive-behavioral therapy program. It is similar to Rational Emotive Therapy and Beck's Cognitive Therapy Model. The primary difference is that the CMRPT applies cognitive-behavioral therapy principles directly to the problem, teaching chemically dependent clients how to maintain abstinence from alcohol and other drugs.

The CMRPT heavily emphasizes affective therapy principles by focusing on the identification, appropriate labeling, and communication and resolution of feelings and emotions. The CMRPT integrates a cognitive and affective therapy model for understanding emotions by teaching clients that emotions are generated by irrational thinking (cognitive theory) and are traumatically stored or repressed (affective theory). Emotional integration work involves both cognitive labeling and expression of feelings and imagery-oriented therapies designed to unrepress memories. The model relies heavily on guided and spontaneous imagery and sentence completion and repetition work designed to create corrective emotional experiences.

This model is also similar to and has been heavily influenced by the Cognitive-Behavioral Relapse Prevention Model developed by Marlatt and Gordon (George 1989; Marlatt and Gordon 1985). The major difference is that the CMRPT integrates abstinence-based treatment and has greater compatibility with 12-step programs than the Marlatt and Gordon model.

The CMRPT integrates well with a variety of cognitive, affective, behavioral, and social therapies. Its primary strength is that it allows clinicians from varying clinical backgrounds to apply their skills directly to RP. As a result, it is ideal for use by a multidisciplinary treatment team.

2.2 Most Dissimilar Counseling Approaches

The CMRPT is most dissimiliar to the following types of therapy:

1. Therapies that view chemical addiction as a symptom of an underlying mental or psychological problem.
2. Controlled drinking or self-control training that promotes controlled or responsible use for chemically dependent clients who have exhibited physical and psychological addiction to alcohol and other drugs.
3. Nondirective or client-centered approaches.
4. Any form of therapy that isolates or exclusively focuses on any single domain of physical, psychological, or social functioning to the exclusion of the other domains of functioning.

The CMRPT is very different from rigid cognitive therapy models, which believe the challenge of irrational thoughts will bring automatic emotional integration, or rigid affective therapy models, which believe that emotional catharsis work will automatically result in spontaneous cognitive and behavioral change.

3. FORMAT

The CMRPT uses a standard session format for problemsolving group therapy, individual therapy, and PE.

3.1 Modalities of Treatment

The CMRPT uses a standard session model of problemsolving group therapy consisting of group rules, group responsibilities, a standard group format, and a problemsolving group counseling format.

3.1.1 Group Rules. The following rules are used as part of the problemsolving group process.

1. Group members can say whatever they want, whenever they want. Silence is not a virtue in the group and in fact can be harmful to a group member's recovery.
2. Group members can refuse to answer any questions or participate in any activity other than basic group responsibilities. Group members cannot be forced to participate, but they have the right to express their feelings about any member's silence or any member's choice not to get involved.
3. What is said and takes place in the group stays among the members. Only counselors can consult with fellow counselors to offer members better, more effective treatment.
4. No swearing, putting down, fighting, or threats of violence are permitted. The threat of violence is considered as good as the act.
5. No dating, romantic involvement, or sexual involvement among the members of the group is permitted, as these activities can sabotage the treatment of either one or both. If such involvement does begin, it should immediately be brought to the attention of a counselor.
6. Anyone who decides to leave the group must inform the group (in person) prior to departure.
7. Group members should be on time for the 2-hour sessions and should not plan to leave before the session ends. No smoking, eating, or drinking is permitted.

3.1.2 Group Responsibilities. Group members agree to fulfill the following basic group responsibilities:

1. Offer their reaction at the beginning of each session.

2. Volunteer to work on a personal issue in each group session.

3. Complete all assignments and report to the group on what was learned.

4. Listen to other group members when they present problems.

5. Ask questions to help clarify the problem or proposed solution.

6. Offer feedback about the problem and the group member presenting the problem.

7. When appropriate, share personal experiences with similar problems.
8. Complete the closure exercise by reporting to the group what was learned in the session and what could be done differently as a result of what was learned.

3.1.3 Problemsolving Group Counseling Format. The group therapy sessions follow a standard eight-part group therapy protocol. The first and last steps of the protocol (preparation and debriefing) are attended by the therapy team only. The other steps in the protocol take place during the actual group therapy session.

1. Preparatory session. The session begins by reviewing clients' treatment plans, goals, and current progress in implementing treatment interventions. Each client's progress is reviewed, and an attempt is made to predict the assignments and problems that the client will present.

2. Opening procedure (5 minutes). The counselor sets the climate for the group, establishes leadership, and helps clients warm up to the group process.

3. Reactions to last session (15 minutes). Each group member describes his or her thoughts and feelings about the session and identifies three persons who stood out from that session and why they were remembered.

4. Report on assignments (10 minutes). Exercises that clients are working on to identify and manage relapse warning signs or deal with other problems related to RP are shared or are completed during the session; other assignments are completed between sessions.

   Immediately following each member's reactions, the counselor asks all group members who have received assignments to briefly answer the following questions:

   - What was the assignment and why was it assigned?

   - Was the assignment completed and, if not, what happened when it was tried?

   - What was learned by completing the assignment?

   - What feelings and emotions were experienced while working on the assignment?

   - Were there any issues that required additional work by the group?

   - Is there anything else that needs to be worked on in group today?

5. Setting the agenda (3 minutes). After all assignments have been shared, the group counselor identifies those group members who want to work and announces their names and the order in which they will present. Those who do not present their work during this session are first on the agenda in the next one. It is best to plan on no more than three members presenting in any group session.

6. Problemsolving group process (70 minutes). Clients present issues to the group, clarify them through group questioning, receive feedback from the group and (if appropriate) from the counselor, and develop assignments for continued progress.

7. Closure exercise. When about 15 minutes remain in the group session, the counselor asks each member to share the most important thing he or she learned in group and what could be done differently as a result of what was learned.

8. Debriefing session. This session reviews the client's problems and progress, improves the group skills of the counselor, and helps prevent counselor burnout. It is especially helpful if this can be done with other counselors running similar groups. A brief review of each client is completed, outstanding group members and events are identified, progress and problems are discussed, and the personal feelings and reactions of the counselor are reviewed.

3.2 Ideal Treatment Setting

The ideal setting for the CMRPT is a primary outpatient program made up of a minimum of 12 group sessions, 10 individual therapy sessions, and 6 PE sessions administered over a period of 6 weeks. Clients with literacy problems, cognitive impairments, or mental and personality disorders usually require longer lengths of stay to complete the therapeutic objectives. Clients are detoxified in a variable-length-of-stay inpatient or residential facility. During detoxification, the client is stabilized, assessed, and motivated to continue with the CMRPT in a primary outpatient program. After completing the primary outpatient program, the client is transferred to an ongoing group and individual therapy program (four group sessions and two individual sessions per month) to implement the warning sign identification and management procedures and update the RP plan based on experiences in recovery.

Brief readmission (3 to 10 days) for residential stabilization may be required should clients return to chemical use, develop severe warning signs that render them out of control and at risk, or put them at high risk of returning to chemical use.

The CMRPT is well adapted for use with chemically dependent criminal offenders in the criminal justice system who have antisocial personality disorders. The CMRPT is most effective when integrated with the cognitive-behavioral method for identifying and managing criminal thinking. In such programs, the model needs to be initiated in residential treatment during the last 12 weeks of incarceration, continued in a halfway setting for a period of 3 to 6 months, and then continued in a primary outpatient program for a minimum of 2 years.

3.3 Duration of Treatment

The CMRPT can be administered in a variety of settings over a variable number of sessions.

3.3.1 Residential Rehabilitation Model. The CMRPT was originally used in 28-day residential programs and administered over a course of 20 90-minute group therapy sessions, 12 individual therapy sessions, and 20 90-minute PE sessions. The protocol was supplemented by involvement in self-help groups. Clients were then transferred into a 90-day outpatient program consisting of 12 90-minute group therapy sessions (once per week) and six 60-minute individual therapy sessions (twice per month). This was supplemented by attendance at 24 12-step meetings and 6 RP support groups.

3.3.2 Primary Outpatient Program. The CMRPT was later used in an intensive outpatient program consisting of 10 individual therapy sessions, 12 group therapy sessions, 6 PE groups, and attendance at 6 12-step meetings and 6 RP support groups. Clients were then transferred to a 90-day warning-sign identification management group consisting of 12 group therapy sessions and 6 individual therapy sessions and continued involvement in 12-step meetings and RP support groups.

3.3.3 PE Programs. The CMRPT has been delivered as a PE program consisting of between 8 and 24 education sessions ranging from 1½ to 3 hours per session. Motivated clients with adequate reading and writing skills have been able to benefit from involvement in these programs. These PE programs are usually integrated with the residential or primary outpatient programs.

3.4 Compatibility With Other Treatments

The CMRPT is compatible with a variety of other treatments, including 12-step programs; family therapy; and a variety of cognitive, affective, and behavioral therapy models.

The CMRPT works well with court diversion programs and employee assistance programs (EAPs). A special occupation RP protocol has been developed for use in conjunction with EAP referrals. This protocol focuses on identifying on-the-job relapse warning signs and teaching EAP counselors and supervisors how to intervene on those warning signs as part of the supervision and corrective discipline process.

A special protocol for working with chemically dependent criminal offenders has also been developed. This model integrates the treatment of criminal thinking and antisocial personality disorders with chemical addiction recovery and RP methods. The protocol integrates a biopsychosocial model, a developmental model of recovery, and a relapse warning sign model designed for clients with antisocial personality disorders and other Cluster B personality disorders. This model is designed to be administered in long-term treatment as the client moves from incarceration to halfway house to intensive outpatient to ongoing outpatient settings over a period of 1 to 5 years.

Specialty application of the CMRPT has been developed for clients with posttraumatic stress disorder (PTSD) resulting from child physical and sexual abuse (Trotter 1992).

Since the protocol identifies and develops management strategies for a variety of problems that cause relapse, coexisting mental disorders and lifestyle problems are often identified and treated in conjunction with RP therapy.

A special protocol for family therapy was developed to facilitate family involvement in warning sign identification and management. Johnson-style family intervention methods were adapted for use in a family-oriented relapse early intervention plan.

3.5 Role of Self-Help Programs

Because it is based on a disease model and abstinence-based treatment, the CMRPT is designed to be compatible with 12-step programs. A special interpretation of the 12 steps was developed to help clients relate 12-step program involvement to RP principles.

Special self-help support groups called Relapse Prevention Support Groups (Gorski 1989*b*) were developed to encourage clients to continue in ongoing warning sign identification and management.

4. COUNSELOR CHARACTERISTICS AND TRAINING

The CMRPT is designed to be implemented at one of three levels: basic research prevention therapy (RPT), recovery-oriented RPT, and psychotherapy-oriented RPT. Different credentials are recommended for practice at each of these three levels.

4.1 Educational Requirements

Professionals with a variety of credentials—ranging from nondegreed certified addiction counselors to doctoral-level clinical psychologists—have been trained and successfully practice the CMRPT. The more training a counselor has in chemical addiction treatment and cognitive behavioral therapy, the more effective he or she is in utilizing the CMRPT.

4.2 Training, Credentials, and Experience Required

Many counselors and therapists are able to use CMRPT techniques effectively after reading *Staying Sober: A Guide for Relapse Prevention* (Gorski and Miller 1986) and the *Staying Sober Workbook* (Gorski 1988), which outline the basic theories and clinical procedures. It is recommended that counselors become competency certified by completing a 6½-day training course and competency certification procedure.

4.3 Counselor's Recovery Status

Whether or not a counselor is in recovery is irrelevant to the delivery of the CMRPT. It is important that the counselor believe in abstinence-based treatment, avoid the use of harsh psychonoxious confrontation, have good communication skills and well-developed helping characteristics, and be a role model for a functional and sober lifestyle. The capacity for empathy with the relapse-prone client is essential.

4.4 Ideal Personal Characteristics of Counselor

Ideally, the RP counselor would be a recovering chemically dependent person with a past history of relapse who recovered using RP therapy methods, currently has over 5 years of uninterrupted sobriety, and has a master's degree or above with advanced training in cognitive, affective, and behavioral therapy techniques.

4.5 Counselor's Behaviors Prescribed

RP counselors are trained to enter into a collaborative relationship with their clients. Supportive and directive approaches that avoid harsh, psychonoxious confrontation are required. A foundation of good basic counseling and therapy skills is required. Additional training in the procedures of the CMRPT is essential.

4.6 Counselor's Behaviors Proscribed

RP counselors are discouraged from becoming harshly confrontational. Confrontation is designed to be directive and supportive, with the counselor pointing out self-defeating ways of thinking and acting while advocating the basic integrity of the client. Any form of confrontation that disempowers the client or attacks the client's core integrity as a human being is seen as inappropriate.

The model is consistent with the professional code of ethics for counselors and therapists in that it proscribes personal relationships and romantic or sexual involvement with clients.

4.7 Recommended Supervision

Supervision should be maintained on a regular basis and should combine both group supervision and individual supervision. Supervision should be problem focused and address issues of how to adapt the standard protocols to meet the individual needs of clients.

Personal issues of the counselor only become a focus of the supervision when personal characteristics begin to interfere with the use of the effective use of the standard protocols. Should this occur, the supervisor generally addresses the immediate problem interfering with treatment and develops a plan with the counselor to modify his or her approach. Should problems continue, the counselor is referred to an EAP or a private therapist to resolve the private issues that are interfering with the therapy processes.

5. CLIENT-COUNSELOR RELATIONSHIP

5.1 What Is the Counselor's Role?

The counselor plays the role of educator, collaborator, and therapist. The counselor has a prescribed series of RP exercises to use that guide a client through the context of group therapy and individual therapy sessions and structured PE programs. The goal is to explain each procedure or exercises, assign appropriate homework exercises, and process the results of the homework in group and individual therapy sessions. The aim is to help clients recognize and manage relapse warning signs by facilitating insight, catharsis, and behavior change.

5.2 Who Talks More?

The client is expected to play an active role in the RP therapy process. The client is given a series of assignments and is expected to actively process those assignments in group and individual therapy sessions. Many of the assignments involve peer support and sharing of information and experiences.

5.3 How Directive Is the Counselor?

The counselor is very directive in establishing the agenda and maintaining compliance with standard clinical procedures. It is the counselor's job to adapt the standard procedures to meet clients' needs. The counselor expects clients to learn basic therapeutic skills and use them in the counseling process. Although the counselor directly enforces the use of a clinical procedure or process, he or she is careful to allow clients to provide the content for the therapy. Special care needs to be taken not to project problems on the clients that they do not have.

6. TARGET POPULATIONS

6.1 Clients Best Suited for This Counseling Approach

Clients who do well with the CMRPT have average or above-average conceptual skills and eighth grade or better reading and writing skills but no learning disabilities, severe cognitive impairments, active impulse control disorders, or other diagnosis that interferes with the ability to participate in a structured cognitive-behavioral therapy program. In addition, they have been detoxified.

6.2 Clients Poorly Suited for This Counseling Approach

Clients who do not do well with the CMRPT are below average in conceptual level; have significant literacy problems; and have organic impairments, learning disabilities, or other mental disorders that interfere with their ability to respond to cognitive-behavioral therapy interventions.

6.3 Adaptation to Special Populations

The CMRPT is adaptable to the needs of a variety of client populations. The techniques have been used successfully with cocaine addicts, adolescents, revolving-door detox clients, physically and sexually abused men and women, criminal justice system populations, and clients with dual diagnosis. The basic protocol, however, must be adapted to meet the needs of the specialty client group.

7. ASSESSMENT

Clients undergo a comprehensive screening interview to determine their appropriateness for the CMRPT. A comprehensive analysis of the client's presenting problems, life and addiction history, and recovery and relapse history are then completed. A standard checklist of relapse warning signs is used to initiate warning sign identification and management.

8. SESSION FORMAT AND CONTENT

8.1 Format for a Typical Session

The CMRPT uses problemsolving group therapy, individual therapy, and PE session formats. Clients are asked to make a commitment to a structured recovery program, to look at self-help groups, and to consider holistic health approaches, including diet, exercise, and social and spiritual activities.

8.2 Several Typical Session Topics or Themes

Therapy is primarily directed toward the identification and management of relapse warning signs. This model consists of 37 structured exercises that have been developed over 20 years of clinical experience. These are presented in detail in *The Staying Sober Workbook*. The primary focus of all sessions is to guide clients in completing these exercises, which result in a personalized list of relapse warning signs (the unique personal problems that lead the client back to alcohol and other drug use) and warning sign management strategies (concrete situational and behavioral coping strategies for managing the warning signs without returning to chemical use).

Clients are involved in a structured recovery program that provides holistic health maintenance for a healthy and sober lifestyle. Breaks in the recovery program are viewed as critical relapse warning signs, and immediate intervention is initiated when they become apparent.

Other problems in recovery include situational life problems and symptoms of dual diagnosis, which are viewed as relapse warning signs. Management strategies are developed that provide direct treatment for these conditions and disorders as part of the RP therapy plan.

Clients with dual disorders are treated in specialty RP programs with other relapse-prone chemically dependent clients with the same disorder, or they are referred for concurrent treatment in close coordination with RP therapy.

8.3 Session Structure

The CMRPT program is highly structured; compliance with the basic therapeutic structures is strongly emphasized and is a prerequisite for involvement.

8.3.1 Group Therapy Format. Group therapy participants learn a standard problemsolving group process that guides problem resolution. The seven-step process is:

1. Identify problems. Have clients ask questions to identify what is causing difficulty. *What is the problem?*

2. Clarify problems. Clients are encouraged to be specific and complete. *Is this the real problem, or is there a more fundamental problem?*

3. Identify alternatives. Have clients list alternatives on paper so they can readily see them. Then have the group come up with a list of at least five possible solutions. This gives clients more of a chance of choosing the best solution and gives them alternatives if their first choice does not work. *What are some options for dealing with the problem?*

4. Project consequences. Have clients project implications of each alternative. *What are the best, worst, and most likely outcomes that could be achieved by using each alternative solution?*

5. Make a decision. Have the group ask which option offers the best outcome and seems to have the best chance for success. Have the group then make a decision based on the alternatives.

6. Take action. Once the group decides on a solution to the problem, they need to plan how they will carry it out. The plan should answer the question, *What can be done about it?*

7. Follow up. Ask clients to carry out their plans and report back on their progress.

8.3.2 Individual Therapy Format. The goal of individual therapy is to assist the client in identifying and clarifying problems and preparing to present them in group. A standard agenda is used.

- Reactions to previous session. The counselor discusses the client's reactions to the previous individual and group therapy sessions.

- Sobriety check. The counselor asks the client if he or she has stayed clean and sober, experienced any cravings or urges to use alcohol or other drugs, and attended and participated in all scheduled recovery activities.

- Clinical work. The issues that the client is currently working on are reviewed in depth. During this part of the session the counselor presents and identifies problems, clarifies the work to be done, and motivates the client to present issues in group. If intense cathartic work is required, this is usually done in individual sessions rather than in group therapy sessions.

- Preparation for group. Each client rehearses how he or she will present issues to the group. The primary goal is to prepare and support each client in efficiently working on issues in group. Group is viewed as the primary or central treatment modality with individual therapy playing a supportive role.

8.3.3 PE Group Format. A standard PE group format is used that is based on proven adult learning principles.

- Pretest. Participants are given a pretest to determine their knowledge level at the beginning of the sessions.

- Lecture. A brief lecture is given describing the basic information for the class.

- Group exercise. A group learning exercise is completed that requires all class members to become actively involved in using the material they heard in the lecture.

- Posttest. Participants are given a posttest to see if they changed any of their answers as a result of the sessions.

- Discussion. The counselor facilitates a group discussion and question-and-answer session to review the correct answers to the test.

The lecture topics used relate to four general areas:

1. Biopsychosocial disease process. The biopsychosocial symptoms of chemical addiction and other behavioral health disorders are explained. This topic is designed to help clients recognize and accept their chemical addiction and dual disorders and make a commitment to recovery.

2. Developmental recovery process. The developmental stages of recovery from chemical addiction and other behavioral health disorders are explained. The educational exercises focus on helping clients identify their particular stage of recovery and develop appropriate recovery plans. The topic is designed to help clients recognize their current stage of recovery, develop an immediate recovery plan, and anticipate future long-term recovery needs.

3. The relapse process. The common warning signs that precede relapse are explained, as are methods to identify and intervene on warning signs without using alcohol or other drugs. The process of relapse, early intervention, and rapid stabilization is also

explained. This topic is designed to help clients recognize their personal relapse warning signs and to develop RP and early intervention plans.

4. Accessing recovery resources. Recovery resources, such as ongoing counseling, 12-step programs, Rational Recovery groups, and other sobriety support programs are explained. The goal is to teach clients how to build a structured long-term recovery program based on inexpensive and readily available community resources.

The CENAPS Corporation publishes a comprehensive guide to recovery education called *The Staying Sober Recovery Education Modules*. This manual contains detailed education sessions following the processes described earlier for each vital educational area.

8.4 Strategies for Dealing With Common Clinical Problems

The CMRPT relies heavily on structured program procedures. The process is initiated with client contracting, and a commitment is secured for attendance, punctuality, and willingness to comply with client responsibilities and active participation within the session structures. Clients who refuse to make such a commitment are viewed as poor candidates for the program and are not admitted for therapy.

In spite of this initial participation contract, routine problems do develop in treatment. All such problems are viewed as relapse warning indicators because they place the client's ongoing therapy at risk and, hence, increase the risk of relapse. The following issues are promptly dealt with as critical issues.

8.4.1 Lateness. Clients are expected to be on time for sessions. Following is the standard procedure for dealing with lateness. Prior to entering group, clients contract to be on time for all sessions.

1. If clients arrive late within the first 15 minutes of group (prior to the end of reactions), they are allowed to stay for that group session only if they agree to work on the issues that prompted the lateness.

2. If clients are more than 15 minutes late for the first session, or if they are late for the second session, they are not allowed in group and must have an individual session with their therapist before being allowed back in group, where they must demonstrate that they have identified and resolved the issue(s) related to lateness.

3. If clients are late on three or more occasions during any 12-week period, they are discharged from the group.

Similar no-nonsense procedures are applied to individual therapy. Only extremely credible excuses are accepted for absence or tardiness and only if there is no pattern of absence or tardiness.

8.4.2 Missed Sessions. Clients are expected to attend all therapy sessions. The only excuse for absence is extreme documented illness (with a physician's note) and serious documented life crisis, such as a death in the family. All excused absences must be called in and be approved in advance by the counselor. Any pattern of three or more absences within any 12-week period is grounds for dismissal regardless of the reasons.

8.4.3 Chemical Relapse and Intoxicated Clients. Intoxicated clients are not allowed to remain in group. If the group counselor suspects a client is intoxicated, the client is asked to verify it in group. If the client denies intoxication but his or her behavior gives reasonable cause to believe alcohol or other drugs have been used, the client is immediately given a breath test for alcohol and a urine drug screen.

Appearing intoxicated for session is viewed as a chemical relapse. The client is immediately removed from group because he or she cannot benefit from therapy when under the influence of mood-altering drugs. An immediate screening appointment is established, and the client is admitted to a stabilization program at the appropriate level of care to deal with withdrawal.

Procedures for dealing with chemical relapses follow.

The counselor deals with relapse to alcohol and other drug use as a medical issue requiring stabilization and treats the client professionally. Anger at the client is viewed as a maladaptive countertransference response, which the counselor needs to resolve in clinical supervision.

If a client refuses to follow recommendations for stabilization, he or she is terminated from treatment. If the client follows stabilization recommendations, he or she is evaluated at the end of stabilization and referred to appropriate ongoing treatment. This usually involves being returned to the same therapist and outpatient group to process the relapse and use material learned to update and revise RP strategies.

In short, relapse is viewed as part of the disease and is dealt with nonjudgmentally and nonpunitively. The relapse is processed so it can become a learning experience for the client.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

The CMRPT views resistance on a continuum from simple denial of chemical addiction to delusion states based on cognitive impairments or severe personality pathology. The underlying cause of the denial is assessed, and special treatment interventions are set up to deal with it.

Since clients in severe and rigid denial are inappropriate candidates for RP therapy, they are referred to transitional counseling programs that are designed to deal with individuals who have high levels of denial and treatment resistance. When clients become treatment ready, they can reapply for admission to the RP program.

8.6 Strategies for Dealing With Crises

Crisis situations are viewed as critical relapse warning signs. The implementation of the standard treatment plan is discontinued, and special crisis management procedures are implemented to stabilize the crisis. Once the crisis is stabilized, the client is reassessed, the treatment plan is updated, and the client returns to working on standard RP tasks as outlined in the treatment plan.

If possible, the crisis is stabilized in the context of the CMRPT. If the crisis is so severe that it interferes with the client's ability to be involved, the client is transferred to another type or level of care to focus on the crisis stabilization.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

The CMRPT has a family treatment component that involves communication and intervention training around the developing warning signs, relapse, and early intervention, which allow the client and family members to have a concrete behavioral response should alcohol or other drug use recur.

Family therapy is normally delivered in a "parallel model." The client is involved in individual and group therapy for recovery from chemical addiction, and family members (especially the spouse or intimate partner) are encouraged to enter individual and group therapy for the treatment of coaddiction and other personal issues. Sessions are established to work with specific couples and family communication training and problemsolving. Special emphasis is placed on developing open communication around recovery goals, relapse warning signs for both chemical addiction and coaddiction, family warning sign identification and management skills, and family intervention planning in the event that alcohol or other drug use or acting out codependent behavior occur.

The goal of family therapy is to remove the chemically dependent partner from the identified client role and create a family recovery focus in which each family member initiates a personal recovery program for chemical addiction or coaddiction. The family then needs to establish a family recovery plan for improving the overall functioning of the family system.

Family therapy is viewed as important but adjunctive to RP therapy. Many relapse-prone clients do not have a committed family system, and many family members refuse to become involved in therapy because of the long history of past failure. Many relapse-prone clients can and do achieve long-term recovery with the CMRPT even though the family is not involved in treatment.

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The Living In Balance Counseling Approach

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1. OVERVIEW, DESCRIPTION, AND RATIONALE

The Living In Balance (LIB) counseling approach is designed as a practical, instructional guide for conducting group-oriented treatment sessions for persons who abuse or are addicted to drugs. This approach has been fully described in *Living in Balance: A Comprehensive Substance Abuse Treatment and Relapse Prevention Manual* (Hoffman et al. 1995). The LIB program is both a psychoeducational (PE) and an experiential treatment model. It is designed so that clients can enter the program at any point in the cycle of sessions and continue in the program until all sessions are completed. The LIB manual is intended for use by professional counselors who have been trained in the provision of alcohol and other drug treatment and is appropriate for use in outpatient, inpatient, or residential treatment settings.

The LIB manual was initially developed by a team of staff members and expert consultants associated with the Center for Drug Treatment and Research for a cocaine treatment research demonstration project funded by the National Institute on Drug Abuse (NIDA). Although it was originally designed specifically for a cocaine abuse population, it is holistic and generic in content and therefore applicable for the treatment of a wide range of drug abuse disorders, including polydrug abuse.

1.1 General Description of Approach

The LIB approach is specifically oriented for the group setting and utilizes techniques that draw from cognitive, behavioral, and experiential treatment approaches, with an emphasis on relapse prevention (RP). The LIB manual uses didactic education and instruction, group process interaction through role plays and discussion, daily relaxation and visualization exercises, informational handouts, videotapes, and group-oriented recreational therapy exercises. Both counselors and clients may find the detailed organization and educational orientation of the LIB manual to be unfamiliar or uncomfortable at first, but over time both counselors and clients are likely to find that the manual provides a solid foundation for treatment that can be used in a flexible clinical context.

There are 36 LIB sessions, each covering one specific topic. The major addiction-related topics include RP, drug education, and self-help education. Physical health issues addressed include nutrition, sexually transmitted diseases (STDs), HIV/AIDS, dental hygiene, and insomnia. Psychosocial topics include attitudes and beliefs, negative emotions, anger and communication, sexuality, spirituality, and the benefits of relationships. In addition, there are sessions on money management, education and vocational development, and loss and grieving.

Each session contains a combination of PE, experiential (behavioral rehearsal and role playing), and group process and RP components. Throughout the LIB program, clients learn to monitor their own feelings and behavior and use relaxation and visualization techniques in the self-assessment and goal-setting processes. Throughout the program clients learn to become actively involved in treatment—learning how to conduct self-assessments and actively implement coping and RP skills. One of the strongest emphases in the LIB program is to teach clients how to become their own relapse preventionists. This includes teaching them about the psychological and physiological components of addiction and recovery, and the various types of interventions and "life skills areas," in which ongoing intervention is necessary. The LIB manual initially included recommendations for the use of several commercial videotapes; however, a set of nine brief videotapes was recently produced to accompany the LIB manual.

1.2 Goals and Objectives of Approach

1.2.1 Goals for Addiction Professionals. The LIB approach is designed to provide addiction professionals with a practical guide to conducting a series of 36 group treatment sessions for people who have drug use problems. The intent of the LIB program is to save addiction professionals time and expense by providing pre-prepared sessions, similar to a teacher's lesson plans.

In many treatment programs, the scope and quality of information and education provided to clients depend on the skills of the counselors working in the program at any given time. Thus, the scope of expertise may be limited, and the accuracy of the information may vary from counselor to counselor. In contrast, the developers of the LIB manual identified the primary issues that should be addressed in treatment and then created therapeutic sessions to address those issues. Thus, the LIB manual provides information about an extensive array of issues of importance to treatment and recovery. Also, the individual sessions of the LIB manual are based on current research in addictive behaviors and RP.

1.2.2 Goals for Clients. Clients in treatment place significant emphasis on the following needs:

1. Information about treatment and recovery.
2. Skills to handle feelings and emotions.
3. Information about preventing relapse.
4. Practical living skills.
5. Open confrontation when engaged in denial or other types of distorted thinking or behaviors.

Thus, the goal of the PE approach of the LIB manual is to provide education, information, and experiences that will show people how to lead healthy and productive lives without using alcohol, cocaine, or other drugs. To achieve this goal, the LIB manual presents accurate information about drugs of abuse, RP, self-help programs, medical and physical health, emotional and social wellness, sexual and spiritual health, daily living skills, and vocational and educational development.

The information is not presented as a long, boring lecture. Rather, each session is divided into manageable segments. Each of the 36 treatment sessions detailed in the manual allows for approximately 90 minutes of counselor interventions, presentations, or client training and includes sufficient time for questions.

After each segment is a question-and-answer session that lets clients intensively interact with the counselor.

During most sessions, there are written assignments that engage clients in an interactive exercise with the information.

When appropriate, there are role-play exercises that encourage intense interaction and discussion among clients.

Each session has one overriding goal with several specific client objectives. Clients are guided through a series of exercises that allow them to develop their own personal goals and objectives for each of the major life areas covered in the various treatment sessions.

Using a combination of cognitive, relaxation, and visualization skills, clients are asked to identify, visualize, and take active steps toward their personal goals and objectives. A sample of a client self-assessment is provided in the Appendix at the end of the chapter.

1.3 Theoretical Rationale/Mechanism of Action

The basic rationale of the LIB model is that persons addicted to drugs develop a sense of imbalance in major areas of life functioning. Continuous drug use generally impairs a person's physical health, emotional well-being, social relationships, work performance, and other major areas of functioning. Recovery involves regaining a reasonable balance in these critical areas. Balance in the major areas of life allows clients to free themselves from their addiction to drugs and provides protection against relapse to drug use. The concept of "living in balance" is essentially a broad, holistic approach to RP.

RP is the single most important component of the LIB program. The first section of the program is devoted primarily to developing RP skills; RP sessions are scheduled strategically throughout the program. The understanding and skills that clients develop in these segments are meant to be used throughout the LIB program on a daily basis. The LIB program approach to RP is based in large part on a cognitive-behavioral model of RP developed by Marlatt and Gordon (1985). In this model, the former drug user confronts a high-risk situation for which he or she has no effective coping response. According to the model, high-risk situations can occur for many reasons, including social pressure to use drugs, negative emotions, and, less frequently, withdrawal symptoms and positive emotions. The lack of a coping response combined with positive expectancies for the initial effects of the drug in the situation greatly heighten the risk of a slip (Hall et al. 1991).

Regarding relapse, the model suggests that "a person headed toward a slip makes numerous small decisions at the time which, although seemingly small and irrelevant at the time they are made, actually bring the individual closer to the brink of the slip. A chain of small decisions can lead, over time, to relapse" (Marlatt and Gordon 1985).

The biopsychosocial LIB approach to this patterning and slip chain is to rework it—to offer clients information about high-risk physical, social, and psychological situations and the potential impact of "small decisions"; to offer clients training in coping responses and stress reduction strategies; and to guide clients down alternative paths to pleasure and other life satisfactions.

LIB RP helps clients:

- Identify situations that trigger cravings.
- Understand the chain of events, including "small decisions," that lead from trigger to drug use.
- Disrupt the chain at an early point.
- Cope with triggers by using thought-stopping, visualization, and relaxation techniques.
- Develop immediate alternatives to drug use.
- Develop a long-term plan for full recovery.

RP is viewed as a fundamental component of treatment and is consequently emphasized in the LIB manual by the use of repeated RP sessions. These sessions are intended to reinforce critical RP concepts and allow clients the opportunity to discuss and process difficult situations that they face in their daily lives that could easily lead to slips or full-blown relapse. Intensive use of visualization exercises is intended to strengthen RP skills and aid in forming and reinforcing personal goals.

1.4 Agent of Change

The agent of change in the LIB model is multidimensional, involving interaction among the group counselor, the client, and the other group members. Although a highly structured format is provided for conducting the group sessions, the counselor is encouraged to utilize his or her personal skills and experience to engage and involve the clients in treatment. In addition, group interaction is highly encouraged, and many of the activities such as role plays, discussions, and games are designed to facilitate group interaction and elicit emotional responses and social bonding. Intrapersonal techniques such as visualization, meditation, and even homework exercises are also extensively used, as they require personal responsibility and discipline on the part of the client for maximum benefit.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

In the LIB approach, addiction is viewed as a biopsychosocial process that not only handicaps an individual's functioning but also may destroy the cohesiveness of family and community relationships. Biopsychosocial processes refer to the inherited biological vulnerabilities, psychological predispositions, and pervasive social influences that converge to both form and perpetuate addictive behaviors.

1.5.1 Biological Factors. Although related evidence is equivocal regarding biological contributions to addictive behaviors, it has been a common belief that some people are born with a genetic predisposition for developing an addiction when exposed to psychoactive drugs. Following chronic drug use, all people experience a severe biological (neurochemical) imbalance. Drug hunger, intoxication, and withdrawal are all manifestations of drug-induced imbalances of biologic homeostasis.

1.5.2 Psychological Factors. Some people begin their drug use to diminish potent emotional and psychiatric symptoms. In turn, addiction causes a variety of psychological problems; drug use and withdrawal can cause numerous psychiatric symptoms. Even recovery can cause severe emotional turmoil. Importantly, addiction causes distortions in thinking such as denial, minimization, and projection.

1.5.3 Social Factors. Various environmental factors increase the likelihood of exposure to specific drugs. For instance, certain drugs are more frequently used within certain cultures, and certain drugs are more easily found in certain geographic areas. For many people, drug use occurs in the context of a social network. In addition, addiction frequently causes severe disruptions in people's social lives. Various social and environmental factors can also contribute to the triggering of drug hunger and relapse.

Addiction is further viewed as a chronic, disabling condition in which relapses are common. Each client's unique history and evolution of addiction must be evaluated at each of these levels, so that an effective treatment plan can be tailored to the client's needs, strengths, and weaknesses. The more comprehensive the intervention, the more successful the outcome is likely to be. Because addiction affects multiple areas of clients' lives, treatment efforts should address all major areas of living.

The LIB program takes a nonjudgmental approach to addiction and lifestyle issues. In general, clients are viewed as people with a compulsive disorder that often overwhelms good intentions and willpower. Clients can be taught RP techniques to avoid a reemergence of the symptoms of addiction: compulsion, loss of control, continued use despite adverse consequences, and relapse.

2. CONTRAST TO OTHER COUNSELING APPROACHES

Addiction treatment using a PE group approach has been recommended to help clients learn basic life skills in order to confront daily problems and as a means of enhancing self-esteem (La Salvia 1993). The LIB model is most similar to other PE programs that utilize a cognitive-behavioral approach with an emphasis on RP. LIB contrasts with these similar models, as well as the 12-step model originating from Alcoholics Anonymous (AA), which is not highly dissimilar to LIB but instead places an emphasis on different issues.

2.1 Most Similar Counseling Approaches

The initial development of the LIB model drew some of its basic concepts from the Neurobehavioral Treatment Model (The Matrix Center 1989), particularly regarding the RP strategies. Some of the materials and handouts on RP were adapted from information in the Matrix Center's manual. The primary difference between the Matrix neurobehavioral model and the LIB model is LIB's emphasis on structured group counseling. The neurobehavioral model is a more flexible approach utilizing a combination of individual, family, and group therapies, with much less emphasis on group processing and experiences.

The LIB model and the neurobehavioral model are also similar to other cognitive-behavioral approaches such as those developed for alcohol treatment as described in *Treating Alcohol Dependence: A Coping Skills Training Guide* (Monti et al. 1989). This approach also emphasizes client mastery of skills that will help them maintain abstinence from alcohol and other drugs. Clients are instructed to identify high-risk situations that may lead to relapse and analyze the external events, the internal cognitions, and the emotions that may precipitate relapse. Clients then develop plans and practice skills to cope with these situations, thoughts, and feelings, using various problemsolving, role-play, and homework exercises.

Many of these basic RP concepts and techniques were based on the original work of Marlatt and Gordon (1985) and Gorski and Miller (1986). LIB uses these concepts in a simple and direct manner and expands on this approach to incorporate a comprehensive holistic view toward lifestyle change.

2.2 Most Dissimilar Counseling Approaches

The 12-step addiction treatment model is most commonly used in addiction treatment programs. Its approach is grounded in the concept of addiction as a spiritual and medical disease, and its content is consistent with the 12 steps of AA. In addition to abstinence, a major goal of this treatment approach is to foster each client's commitment to participation in AA and Narcotics Anonymous (NA) self-help groups. Therapy sessions generally follow a similar format that includes symptoms inquiry, review and reinforcement for AA/NA participation, and introduction and explication of each session's theme within the AA/NA philosophy (acceptance and surrender to the higher power, moral inventories, and sober living.) Material introduced during treatment sessions is often complemented by reading assignments from AA and NA literature.

The LIB approach is not completely dissimilar to the 12-step approach and in fact incorporates many of its concepts and encourages participation in its self-help programs. LIB, however, places a much greater emphasis on learning and practicing critical RP skills and on strengthening major areas of a client's life to reinforce protection against relapse. Like 12-step programs, LIB encourages spiritual exploration (finding a source of involvement greater than the self). But the primary focus remains on making informed decisions in everyday life that help the client regain balance and prevent relapse to drug use.

3. FORMAT

The LIB counseling approach is designed for group counseling in any type of drug treatment setting. It can be used as a primary modality over a period of 4 to 6 months, in combination with other treatment approaches (e.g., medical and psychosocial modalities), and for varying lengths of time. LIB incorporates a self-help approach and encourages participation in self-help programs that the client determines most suitable to his or her needs and personal philosophy.

3.1 Modalities of Treatment

The LIB program is designed for use in a group counseling format. Groups may range in size from 5 to 20, but a group numbering between 12 and 15 has been found to provide a good balance between individual attention and group processing. LIB can be combined with other modalities such as individual and family psychotherapy and can be modified in accordance with the needs of specific treatment programs.

3.2 Ideal Treatment Setting

The LIB program can be used in drug abuse treatment settings as the core treatment or as an adjunct treatment strategy, depending on the clinical setting, level of care, and type of program. The LIB program can be used in all levels of care:

- Inpatient or outpatient.
- Intensive outpatient.
- Partial hospitalization.
- Continuing care and aftercare.
- Evening or weekend programs.

The LIB program can be used in a variety of program types:

- Freestanding.
- Hospital based.
- Community based.
- Corrections based.
- Counseling centers.
- Methadone treatment.
- Therapeutic communities.
- Halfway houses.
- Therapists in private practice.

The LIB program has been designed by a multidisciplinary team of healthcare professionals for use by trained addiction professionals. In many treatment programs, the LIB manual will be used primarily by addiction counselors and therapists. Some treatment programs may choose to have various healthcare professionals lead some of the group treatment sessions in their areas of expertise. Physicians may lead the sessions on STDs, nurses may lead the sessions on physical well-being, and nutritionists may lead the session on nutrition.

3.3 Duration of Treatment

The LIB manual is divided into 36 sessions. Each session lasts about 2 hours and is held 3 days a week over a 12-week period (allowing for holidays and special events), or less frequently over a longer period of time. Specific sessions have been identified for different treatment settings, populations, and levels of care. The LIB program is designed so that clients can enter into the program at any session and continue the program until all of the intended sessions are completed.

3.4 Compatibility With Other Treatments

The LIB program can be used as the primary modality of treatment in an intensive outpatient program or in combination with other common modalities. Hoffman and colleagues (1994) found that when LIB groups were conducted 5 days a week, adding individual and family psychotherapy contributed little to increasing either the number of days or the number of sessions attended in outpatient treatment for cocaine abuse. However, when LIB groups were offered only twice a week, adding individual and family psychotherapy significantly increased the number of sessions attended. LIB has also been used effectively in methadone treatment programs, particularly during the early phases (Moolchan and Hoffman 1994). When used properly within the confines of a comprehensive treatment program, medication (including methadone) is viewed by the authors of the LIB concept as a useful adjunct in helping clients regain and maintain a life of balance and sobriety. LIB is also currently being used in residential treatment programs and specialized programs for drug-abusing women.

3.5 Role of Self-Help Programs

The LIB program views the 12-step programs of AA, NA, and Cocaine Anonymous (CA) as important components in the treatment and recovery process for cocaine addiction. The LIB manual introduces clients to this and other self-help programs and encourages clients to attend self-help meetings during and following the formal treatment program. In addition, the manual embraces alternative recovery self-help groups and promotes spiritual awareness. The LIB manual also incorporates 12-step program references and examples throughout the text. Each client must find his or her own sources of support and fulfillment that extend beyond the limits of a treatment program and professional counseling.

4. COUNSELOR CHARACTERISTICS AND TRAINING

The effectiveness of any treatment model or counseling approach is determined by the personnel who use the model or deliver the program. The background, training, education, and experience of LIB counselors are critical to the effective use of this approach. Counselors who have more clinical training and related experience will be more capable of using various components of the model to effectively address the myriad issues that arise during a treatment session.

4.1 Educational Requirements

The LIB model is designed to be used by anyone who has experience as a drug abuse counselor or who has other professional addictions training. Certification as an addictions counselor is also recommended but not required. Although an individual who has a high-school diploma would have adequate reading comprehension skills to use this model, it is recommended that the individual have an associate's, bachelor's, or master's degree. This additional education and training would enhance an individual's ability to fully understand the materials being presented and draw on his or her own experiences in developing certain concepts and ideas that are presented in the various sessions.

Although the LIB manual is written in simple, easy-to-understand language, some of the concepts and exercises actually have very complex underpinnings.

4.2 Training, Credentials, and Experience Required

Ideally, the individual using the LIB approach should have extensive training in the area of addictions. This level of training is encouraged because it provides a conceptual foundation and the skills requisite for any treatment modality. National certification as an addictions counselor is recommended; however, being a certified addictions counselor is not a requisite for using this counseling model. The effectiveness of the model is contingent on the counselor's knowledge of the addictions field, his or her knowledge of various treatment techniques, and his or her experience in using those skills and techniques that are critical for working through the denial and resistance that are characteristic of a drug-using population.

4.3 Counselor's Recovery Status

The LIB counseling approach can be used by counselors who have had a recovery experience or who have never used drugs. A counselor's recovery status is a complex issue that needs to be addressed in counselor training and supervision. It has been found that counselors who are recovering addicts can sometimes use their personal experiences to help illustrate certain points and that they have a greater sensitivity to some clients' responses and concerns. However, it is also important that the recovering counselor have mastery of RP skills and practice them in his or her own life, because a counselor should serve as an example of a person who is leading a relatively balanced life. Counselors in recovery should use their own judgment, preferably in consultation with a supervisor, about when, how, and whether to reveal their own personal recovery experiences. This self-disclosure should be made only with a clear understanding of the potential benefits to the client. At no time should a counselor use the group sessions to discuss or resolve his or her own personal problems.

4.4 Ideal Personal Characteristics of Counselor

While ideal counselor characteristics have not been clearly identified, some basic qualities that are useful in any counselor are sensitivity, a nonjudgmental attitude, and a genuine desire to help people struggle through some of the problems that led to their use of alcohol or other drugs. A counselor using the LIB model should be able to lead group discussions and provide basic instruction for those topics that require didactic presentation. Other personal characteristics that are helpful are openness, honesty, an ability to set appropriate limits, and a capacity for demonstrating caring while confronting behaviors that are inimical to the goals and objectives of the model.

4.5 Counselor's Behaviors Prescribed

The counselor should be skilled at confronting the client in denial. One of the major impediments to successful treatment is a client's denial of his or her addiction. This denial expresses itself in many ways and many forms, from outright denial of having a drug problem to expressions of disinterest in the various topics and an unwillingness to discuss certain subjects. The counselor needs to be able to describe the behavior (e.g., avoiding certain topics, expressing denial), demonstrate the pattern of behavior as it appears, and relate the behavior to the defense mechanism of denial as it expresses itself in the course of treatment.

In addition, the counselor must be adept at pointing out both strengths and weaknesses in a client. Periodically during group sessions, a clear effort should be made to identify strengths that the client has demonstrated over the course of treatment and point out areas where continued growth is necessary. The major emphasis, however, should be on noting strengths.

It is very important that a counselor using the LIB model be prepared. He or she should study and review the session materials in advance of every group meeting so that the topic of discussion is thoroughly understood and can be delivered in a clear, natural, and comfortable manner. Lack of preparation will lead to an inaccurate or stifled presentation of information. The information is not intended to be read verbatim; it should be presented in a personalized and meaningful way. The counselor must understand and be familiar enough with the material to allow him or her to concentrate on group processing and individual needs and concerns.

4.6 Counselor's Behaviors Proscribed

The LIB approach to group work uses virtually all of the skills and intervention strategies that would normally be used in a group setting. Standard group counseling techniques and interventions are generally appropriate within the LIB model, although the approach relies more heavily on PE rather than psychotherapeutic strategies. The LIB model is designed to identify problems and develop skills and strategies for addressing them.

For this reason, the counselor might refrain from using techniques designed to encourage the client to relive traumatic and unresolved childhood and adult experiences or attempt to treat comorbid psychiatric disorders directly in the group setting. Nevertheless, materials, films, and role-play exercises are likely to elicit strong emotional reactions, and it is appropriate to acknowledge and discuss these feelings. Should intense, unresolved emotional issues arise in a group session, the counselor might suggest that the client address these issues in an individual session. The counselor should use his or her judgment in determining whether to seek the assistance of a trained psychologist or psychotherapist.

The counselor should also discourage detailed discussions of drug use that may glorify use or stimulate or trigger a conditioned craving for drugs. In discussions of RP, it is inevitable that drug use will be discussed to some extent. However, the counselor should be careful to reframe the discussion in terms of understanding the precipitants and associations to drug use and should curtail detailed discussions or storytelling not directly pertinent to learning RP skills. If the counselor comes to believe that the discussion may have triggered a craving in a client, the matter should be addressed immediately, and concrete solutions should be identified for disrupting the pattern of behavior that would likely lead to drug use. These situations can sometimes be difficult for a counselor to handle and should therefore be discussed repeatedly in supervision, as will be discussed in the next section.

4.7 Recommended Supervision

The primary goal of supervision is to help the counselor use his or her clinical skills to present the information contained in the LIB manual in a manner that engages the group and facilitates individual recovery.

To achieve this goal, the supervisor should:

- Help the counselor develop his or her basic counseling skills, such as reflective listening and reframing.
- Develop the counselor's skill in the use of the model, particularly in the area of RP training. (The supervisor must ensure that the counselor has a solid grasp of the RP information covered in the LIB manual.)
- Assist in evaluating the emotional state of the group and in helping determine when to use various sessions to meet the treatment needs of the group.
- Assist in dealing with difficult issues in group process, such as clients who dominate the discussion or focus excessively on drug use or drug-related behavior.

The supervisor must know the level of clinical expertise of each counselor under supervision. The supervisor needs to know the extent to which the counselor is comfortable using confrontation, demonstrating empathy, and encouraging supportive group interactions. Also recommended is use of the case conference approach, where LIB counseling staff can develop alternative strategies for problem resolution as each case is reviewed in depth.

Finally, the supervisor must observe group sessions to be able to provide behavioral and skills-based feedback to counselors. These observations are critical in helping counselors develop and enhance their clinical skills.

5. CLIENT-COUNSELOR RELATIONSHIP

The relationship between client and counselor permits the client to use the counselor as a sounding board and to appreciate and value the insights and observations the counselor makes with regard to the client's progress. Therefore, developing a strong relationship, one of caring and concern, is imperative to the counselor's ability to intervene effectively in the life of the client in a manner that is helpful to recovery.

5.1 What Is the Counselor's Role?

In some cases, the counselor is clearly an educator by virtue of the PE approach of the model. The counselor educates the client about matters related to drug abuse, both in terms of the pharmacological or biological impact on the body and the impact that drugs have on other areas of life. In this educator/teacher role, the counselor begins to provide the client with knowledge about the impact of alcohol and other drug use, which will enable the client to make informed decisions regarding his or her use of these drugs.

The counselor also plays the role of therapist in providing clients with a valuable resource for understanding and changing their behaviors in a healthy, productive way. The counselor helps clients understand their feelings about particular areas of their lives and helps them work through their struggles. This model discourages the counselor from being an adviser to the client. The model itself is one that is geared toward empowering the client to take charge and independently make decisions regarding his or her life.

5.2 Who Talks More?

The LIB model requires the counselor to do most of the talking. In most sessions, the counselor initially uses a didactic approach, imparting information regarding a particular subject area. The counselor must then facilitate group discussion and interaction. In a 90-minute session, the counselor will spend about 30 minutes either offering some instruction verbally or engaging the client in some kind of experiential process, where instruction and guidance are offered. The remaining hour of the session is generally devoted to the interactive component of the program, where the client is encouraged to express feelings, reactions, or thoughts regarding a particular topic area.

5.3 How Directive Is the Counselor?

Because LIB requires the counselor to take the lead and guide clients through a structured set of group experiences, the counselor is highly directive. The primary objective of these group experiences is to empower clients to make informed decisions regarding their use of alcohol and other drugs and to begin to lead a more balanced and healthy lifestyle.

5.4 Therapeutic Alliance

The quality of the client-counselor relationship can significantly enhance the impact of any technique used in working with an individual or group. Thus, the most effective counselor develops an alliance with the client that is characterized by honest and clear communication, explicit empathy, respect for the individual, and a clear treatment objective.

The treatment contract is one way of developing such an alliance. The contract should establish explicit goals for the individual and the group, clearly state what the counselor will do to help the group or individual achieve those goals, and articulate behavioral expectations or group rules (e.g., not interrupting, being on time, not leaving the group session unless absolutely necessary).

In situations where the alliance is poor, the counselor needs to explore, with the supervisor, interventions that might strengthen that relationship. For example, if gender is an impediment to establishing a working therapeutic relationship, the counselor needs to determine the efficacy of discussing the issue with the client in an individual session. If the counselor decides to discuss the issue with the client, the counselor should gently state that the client appears to have some discomfort or negative feelings toward the counselor that might be interfering with the client's participation in the group process. The counselor should not be threatening, accusatory, or defensive, but should be accepting of the client's feelings and should try to clarify any wrong perceptions. The counselor should be aware that the client may be reacting to previous negative experiences with treatment. In any case, the counselor should convey concern for the client and work toward improving the alliance.

6. TARGET POPULATIONS

The LIB program was originally designed for an inner-city, predominantly minority, cocaine-abusing population in an intensive outpatient treatment program. Nevertheless, it is applicable for a wide range of drugs of abuse, including heroin and alcohol, and for clients from a wide range of cultural and economic backgrounds. The LIB manual was designed to be universally applicable across various cultural and ethnic backgrounds. Its biopsychosocial and holistic approach to treatment assumes that living a balanced life is a fundamental objective of all people, regardless of race, culture, or ethnic background. Establishing physical, emotional, social, and spiritual well-being is considered to be a central objective in the process of recovery from drug addiction for all individuals.

The role of culture and ethnicity is also a critical element of the recovery process. An addiction counselor's cultural sensitivity is a prerequisite to providing effective treatment. Unless the counselor is aware of and sensitive to the cultural and ethnic issues and concerns of clients in treatment and understands socioeconomic and racial factors, his or her effectiveness will be severely restricted and potentially counterproductive. The counselor must have knowledge of and empathy for the ethnic and cultural experiences, perceptions, and values of his or her clientele.

6.1 Clients Best Suited for This Counseling Approach

Clients best suited for the LIB program are those who are comfortable participating in a group. LIB generally does not involve intense group confrontation or indepth psychodynamic processing; however, the sensitive nature of some of the issues covered requires a minimum level of comfort with group interaction. If a client is not comfortable in this situation, it may be possible for him or her to participate in individual counseling until a later phase of treatment when he or she is more ready to join an LIB group.

The LIB program is generally suitable for clients of all ages (late teens to elderly persons), although it would be ideal to limit participation in each group to specific age ranges so that peers of similar age can address concerns relevant to their experience. LIB can be used with mixed-gender groups and with men-only and women-only groups. (Same-sex groups are preferred and generally recommended when dealing with issues of sexual and emotional abuse.) LIB can be tailored to any ethnic or cultural subgroup and be implemented with users of different types of drugs, and it can include sessions on alcohol and nicotine addiction. LIB has been used with a variety of different groups (e.g., Latino alcoholics, African-American pregnant and postpartum crack-using women, Caucasian methamphetamine users, and mixed ethnic/cultural heroin users).

The LIB program can be used in any type of drug treatment or social service setting and is ideal for use with special populations (e.g., welfare to work, criminal justice, public housing, mental health) where drug abuse problems exist. There are specific sessions that the LIB manual suggests using when dealing with some of the key counseling issues for these populations. LIB complements the 12-step approach, provides information about various self-help-oriented programs, and encourages participation in those programs.

6.2 Clients Poorly Suited for This Counseling Approach

The LIB group counseling approach may not be suitable for clients who are uncomfortable in a group setting. Initial discomfort is common and natural given the implicit pressure to reveal and expose personal feelings to a group of strangers. However, this discomfort quickly diminishes for most clients. Some clients who have high social anxiety, who are extremely introverted, or who have difficulties with logical thought processes may not respond well to this group counseling format. In addition, some of the more educational components of the program may be difficult for clients who have very low reading or cognitive abilities. Although most of the materials are discussed aloud and assistance is available for those who need help with written assignments, clients must have the ability to understand the concepts presented in order to benefit from the program.

The LIB program has been successfully implemented with a diverse group of cocaine-abusers, which included court-referred and dually diagnosed clients. The only notable limitation, as mentioned earlier, is that clients must be able to attend meetings and comprehend the concepts conveyed. Clients with psychotic disorders, for example, may not be suitable candidates for participating in the LIB program if they have difficulty functioning in a group setting or in comprehending the information in an objective manner. However, these clients may be suitable if their severe psychiatric symptomatology is adequately controlled through adjunctive treatments and they can function comfortably in a group setting.

7. ASSESSMENT

An assessment protocol that measures the specific domains covered in the LIB program has not yet been developed. The LIB approach was studied by the authors in a 5-year comparative treatment investigation in Washington, DC, where cocaine-abusing clients were offered either the full 5-day-a-week version or a 2-day version of LIB group therapy. The intensive treatment approach has so far been deemed superior in encouraging higher levels of client participation in treatment, and both approaches appear superior to many prior reports of comparative treatment findings with crack smokers (Hoffman et al. 1994; Wallace 1991).

Measures such as the Addiction Severity Index (ASI) (McLellan et al. 1992), a commonly used measure in addiction research, can be used in assessing the following parameters: client demographics, treatment history, lifestyle and living arrangements, alcohol and other drug use, HIV and AIDS risk behavior, illegal activities and criminal histories, employment status, and mental and physical health status.

8. SESSION FORMAT AND CONTENT

The LIB manual provides a detailed description for 36 treatment sessions in the form of instructional text similar to a teacher's lesson plan. The information is prepared so that counselors can gain a thorough understanding of the topic and present it in manageable segments.

8.1 Format for a Typical Session

In addition to the written instructional text, each session includes:

- Handouts for clients. Questionnaires, assignments, exercises, and lists of additional resources for appropriate topics for clients.

- Presentation transparencies. "Visuals," which are key words and important phrases and concepts presented in each session.

- Videotapes. Nine videotapes that focus on many of the session topics.

- Daily progressive relaxation and visualization exercises. Progressive relaxation exercises that teach clients stress reduction skills. (Exercises correspond to session subject matter and are designed to help clients identify and reinforce recovery-oriented goals that relate to session topics.)

- Relaxation and visualization audiotape. Substituted for counselor-led relaxation exercises. (Also to be used as an adjunct or a model for leading exercises.)

8.2 Several Typical Session Topics or Themes

The LIB manual, with emphasis on PE, was designed to educate clients on how to conduct self-assessments. The manual focuses on specific "life areas," in which prolonged drug use has had a negative impact. The various topics covered in the LIB program are summarized below.

- Visualization, self-assessment, goal setting, planning, and self-monitoring. Clients are offered training in relaxation techniques, goal setting, planning, and self-monitoring. They are instructed in and practice using relaxation exercises as an RP tool to help them intervene in stressful situations and when they experience cravings for alcohol, cocaine, or other drugs. They learn how to set personal goals for recovery, how to conduct self-assessments in key life areas, how to deal with life improvements, and how to practice life skills. Training is repeated throughout the sessions.

- Drug education. Clients learn about the psychological and physiological components of addiction and recovery and about the neurophysiology involved in addiction and recovery. They also learn in great detail about the psychological processes involved in craving and relapse. Clients participate in discussions about the classical conditioning that occurs surrounding internal and external "triggers" or conditioned cues that may elicit craving experiences and in role-play-related interventions and learn techniques to diminish the power of conditioned cues.

- Relapse prevention. Clients take part in intensive RP sessions, where they practice RP skills in "process sessions." This is where clients talk about their current risk factors and intervention efforts to prevent relapse and where they can role-play responses to high-risk situations. Clients learn about the operant and classical conditioning that occurs and how specific cues (e.g., people, places, and things; certain times of day; special smells and sounds) that they associate with prior drug use can lead to craving their drug of choice and relapse unless they actively plan and intervene. They also learn how to eliminate or extinguish such learned associations and practice specific skills in coping with high-risk situations. Planning for coping with high-risk situations, generating social support for abstinence, and learning how to cope with unanticipated stress or temptations are all central to these sessions.

- Self-help education. Clients are encouraged to use specific intervention skills such as implementing stress management techniques (discussed earlier) and eliciting social support (recovery groups such as AA, NA, or one of the more recently established secular groups such as Rational Recovery. The primary goal is to ensure that, as an adjunct to treatment, clients have abstinent role models to help them cope during high-risk times and provide them with a form of ongoing support after they have completed the formal treatment provided by the LIB program.

- Sexually transmitted diseases. As part of the session on STDs, clients are given information on various diseases and risk factors for each. An additional session, devoted to HIV and AIDS, emphasizes the risk of contracting HIV within an addict population and explains risk reduction strategies. The various high-risk behaviors that cocaine, alcohol, heroin, and other drug addicts engage in (risky and unsafe sex practices and needle sharing) are discussed, and the importance of reducing all risk behavior for HIV infection is explained. HIV and AIDS testing and treatment are also reviewed.

- Physical well-being. The negative impact of illicit drugs and alcohol, cigarettes, and prescription drugs is discussed; diet, exercise, and overall health maintenance (i.e., medical and dental care and personal hygiene and appearance) are emphasized. Group discussions on these topics as they relate to drug addiction and to a more positive lifestyle are integrated into several sessions.

- Emotional well-being. Specific areas that are emphasized in this area include depression, anxiety, fear, anger and hostility, and guilt and shame. There are also group discussions of these topics as they relate to emotional problems and drug abuse and to the manner in which emotional strengths and problems can influence other life areas.

- Social well-being. Specific topics covered include interactions with friends and relationships with lovers/spouses, parents and parent figures, siblings, offspring, and other significant others (SOs). Discussions in these sessions can show how relationships can be linked to drug abuse and how behaviors associated with drug abuse can be changed. The role that SOs may play in enabling drug use and the peer pressure that can generate drug-abusing behavior and relapse are discussed. Modeling, behavior rehearsal, and role playing are significant components for teaching clients. Generating social support for abstinence and recovery is also a significant part of this topic area.

- Sexuality. The topic of sex and drugs is included in several sessions. Sexual dysfunction, sexual abuse, sexual addiction, sexual behavior as a risk behavior for relapse, and healthy sexuality are discussed, along with the effects of drugs in inhibiting sexual behavior.

- Education and vocational development opportunities. Specific topic areas include reading and language skills, math and technical skills, possible alternatives for further education, relating education to employment goals, and learning for pleasure.

  This is an opportunity for the client to review his or her vocational history, interests and aptitudes, and skills training and preparation to gain, maintain, and enhance employment.

- Daily living skills. Specific topics include transportation, housing, legal assistance, financial assistance, and budgeting.

- Spirituality and recovery. The concept of spirituality, defined globally in the religious sense and also in terms of simply having some sense of purpose, direction, or meaning in life, and its potential utility for recovering addicts is discussed. Other topics include the role of spirituality in providing a positive meaning for life; ritual and symbolism; peace of mind; and beyond the self.

- Grief, loss, and recovery. Each is addressed to educate clients about the relationships between addiction and loss. Responses to loss are addressed, and the process of grief and factors that can affect grief is reviewed. The stages of grief are characterized, and strategies to deal with important losses, including the use of support services, are covered.

- Parents and parenting. Sessions are designed to assist clients in understanding the basic needs of children that they or other caregivers must address, as well as the needs that parents and other caregivers have when parenting children. Developmental stages of children are reviewed, and clients are taught how they can help children in meeting their developmental tasks. The issues that children face at different developmental levels are also addressed. Clients are shown specific parenting skills such as communication skills, problemsolving, and positive reinforcement. Through these discussions, clients may gain a greater understanding of their own development, whether or not they are parents.

8.3 Session Structure

As presented in the LIB manual, the group treatment sessions are relatively organized. They include prepared topics, information, exercises, videos, handouts, and so forth. The materials need not be used exactly as provided; they can serve as a resource for less structured sessions. The group counselor is encouraged to study the materials and use them in a personalized manner. Less experienced counselors may prefer to follow the structure of the LIB manual more closely.

8.4 Strategies for Dealing With Common Clinical Problems

The LIB approach is not immune to the usual assortment of clinical problems. During the admission process, clients should be informed of program policies and the consequences of violating those rules. Invariably, clients will miss sessions, arrive late, or come to treatment under the influence. As with any other program, there should be established policies and procedures governing these matters. When problems are addressed in the context of the LIB program, they provide valuable opportunities for behavioral interventions within the group and with the client. Following are some examples of how these problems might addressed.

8.4.1 Lateness. The program policy should establish lateness as an issue that is discussed in the context of the group. A pattern of lateness affords an opportunity for the counselor to help the group examine how the same faulty planning process that leads to lateness can contribute to relapse. Also, the group can explore the impact of an individual's lateness on his or her social relationships. The group can actually develop a plan to resolve the lateness problem, which can allow clients to develop skills that can be applied to other life situations.

8.4.2 Missed Sessions. Missed sessions are to be expected; therefore, each program should develop a policy that is consistent with its treatment philosophy. In the context of the LIB approach, however, the focus of the intervention should be on the frequency of, and reasons for, missed sessions. Because a client's absence has an impact on the dynamics of the group, the counselor should use the issue to help group members identify their emotional response to the repeated absences of a member. Also, it is probable that some absences will be a response to feelings that surfaced in the previous session. This presents a perfect opportunity for the counselor to educate the group about the relationship between feelings and behavior.

8.4.3 Attending Sessions Under the Influence. It is the authors' opinion that a client who comes to a session under the influence of alcohol or other drugs should not be allowed to participate. If a client's condition is such that there is concern about allowing the individual out into the community, the client should be held in a separate room until he or she is capable of leaving the program safely. As soon after the incident as possible, an individual session should be held to review what took place and help the client develop a more effective plan for abstinence. If the incident took place in the presence of the group, it should be the focus of an RP session. Otherwise, the counselor should use his or her clinical judgment regarding the appropriateness of discussing the incident in the group session.

These issues should be addressed in a manner consistent with the philosophy and orientation of the treatment program. Although policies and procedures are necessary and should be applied with consistency, their application should be tempered by the clinical needs of clients. It is the authors' opinion that a blanket sanction for all clients, with no consideration for individual differences and individual growth patterns, is problematic and does not allow for maximizing the individualization of the treatment program. An effort should be made, therefore, to impose sanctions in a manner appropriate to the level of development of the particular client.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

It is unrealistic to expect every client to enter treatment acknowledging the severity of his or her addiction and be highly motivated for change. In fact, the very essence of treatment is confronting and overcoming the client's denial, resistance, and lack of motivation. Therefore, an effective model of treatment must incorporate a variety of strategies to address these fundamental barriers to long-term recovery. Following are strategies employed in the LIB model to address these clinical issues.

8.5.1 Denial. Because LIB uses a PE approach to treatment, all of the sessions provide a means for confronting a client's denial. For example, the RP sessions help clients identify thoughts, feelings, and situations that trigger their use of alcohol and other drugs. This process helps teach clients how triggers relate to relapse. Another aspect of denial can be the tendency of clients to blame their drug abuse on others. In the sessions addressing social well-being, clients are guided through an examination of the key relationships in their lives. This examination helps clients understand how their responses to problems in their relationships are reflective of the decisions they make and that their problems cannot be used as rationalizations for their drug abuse. This approach works in many areas of a client's life, such as social relationships, emotional well-being, and other areas where denial may be a factor that prevents the client from moving forward in treatment.

8.5.2 Resistance. Resistance is another area frequently seen in the treatment sessions that merits considerable time and attention. Clients express their resistance in numerous ways: through arriving late to individual or group sessions, distracting behavior during group sessions, challenging and argumentative behaviors, and so on. The LIB program has built in some mechanisms for dealing with resistance: the use of relaxation and visualization exercises and the communication and presentation of information by way of videotapes, handouts, and role plays. In some cases, the counselor should use the topic of a particular session to help clients begin to examine how their behavior may reflect resistance to treatment.

In light of factors such as denial and resistance, it is imperative that counselors use the group to assist in their interventions. Interventions made by the counselor carry significant weight, but when the group can help a member recognize denial or resistance by observing the member's behavior and sharing their own experiences with denial or resistance, such continued intervention can have a tremendous impact on the client's overcoming resistance to treatment.

8.5.3 Poor Motivation. Poor motivation is another area that will inevitably need to be addressed during the course of treatment. It is usually best for the counselor to discuss an apparent lack of motivation with the client outside of the group sessions. It may be determined that there are other clinical issues that are upsetting the client or interfering with his or her ability to concentrate or participate in the group sessions. Once the lack of motivation is openly acknowledged, the client will be faced with the choice of engaging in treatment or discontinuing participation.

8.6 Strategies for Dealing With Crises

It is inevitable that clients will come to the program with a variety of crises. When this happens, the counselor should establish the nature of the crisis and evaluate the appropriate intervention to be made at that time. It may be necessary for a client not to participate in the group but to work with a therapist to resolve a personal crisis. In this case, it would be appropriate to excuse the client from group participation until the crisis is resolved. Once the crisis is over, and with the client's permission, a discussion of the crisis in the context of the LIB session might be a valuable learning experience for both the client and the group. This could be accomplished by presenting the issue during RP or in the course of another session. Working the crisis into the session would provide an opportunity for the client to examine how the crisis developed, how he or she dealt with it, and what could be done in the future to avoid it. In addition, it allows the group the opportunity to identify with the dilemma in which the client found himself or herself and to use that person's experience to help others in examining their own feelings and thoughts about the matter. This sharing may also help the other group members work with the client in providing the support and nurturing needed to get through the particular situation. Some crises, however (e.g., recent sexual abuse), may be best dealt with on an individual basis.

8.7 Counselor's Response to Slips and Relapses

While slips and relapses are common symptoms of the condition of addiction, it is not appropriate for the counselor to suggest that clients are expected to have relapses. Therefore, the counselor's first response to slips and relapses should be one of caring and concern, which should be demonstrated to the client through comments, observations, and other means of communicating very clearly that "I am concerned about your health and your ability to stay clean." During RP sessions, the counselor should work with the client to help the client understand how this relapse or slip occurred. The areas to be discussed should include what happened, when it started, how the client addressed it, what should have been done differently to address the problem, and what can be done next time it happens. Through this process, a slip or relapse can be turned into a very powerful learning tool to give the client an opportunity to avoid behaviors that might lead to his or her using alcohol and other drugs in the future.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

It is of vital importance that family members, friends, and others involved with the client be involved in the treatment process, since they have also been affected by the client's use of alcohol and other drugs. The forum recommended for providing involvement for those individuals is family group counseling. Family group counseling can utilize concepts and materials from the various LIB sessions. In this way, families can explore their communication patterns and understand how family issues become triggers for relapse, as well as how the emotional stability and well-being of the family is influenced by the way it handles issues like anger and frustration. Family involvement is included as a separate part of the program, utilizing some of the concepts that have been discussed in the client's group sessions.

10. CONCLUSION

LIB is an intensive, comprehensive, manual-driven drug abuse treatment program that can be implemented in a variety of treatment settings. Its PE and experiential components are geared toward group treatment with the option of adding individual and family group therapy. The LIB manual provides a guide for counselors and facilitators and includes material for 36 counseling sessions, which cover a range of topics to address issues in the key life areas affected by an individual's drug abuse. The manual is intended for use by trained drug abuse professionals who are capable of presenting the material and facilitating group process. The emphasis of the approach is on enabling clients to recognize and forestall relapse to drug abuse and to reestablish a balance and sense of personal fulfillment without the use of drugs.

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APPENDIX. SOCIAL WELL-BEING

NOTE: Either insert the following into today's daily visualization or lead a brief progressive relaxation and visualization with the following information:

Social well-being is an important part of my life. Addiction may have temporarily hurt my social well-being and allowed me to neglect important social relationships.

Therefore, my recovery includes learning to have healthy relationships with others, learning to cooperate and compromise with others, and learning to accept social responsibilities.

My recovery includes learning to find a healthy balance in relationships, such as between positive and negative feelings, between dependence and independence, between leading and following, and between closeness and isolation.

Drugs have had a strong impact on my social life. I may have dropped healthy relationships and made unhealthy relationships that center around drugs. Addiction made it easy for me to have dishonest relationships with my family and friends.

My recovery includes learning to identify my strengths and weaknesses and learning to make goals for myself. I may need to learn how to ask for help. I may receive this help from a friend, a lover, a person I trust, or a group of people. I may receive this help from my Higher Power. I may have to learn to have faith and to be patient.

For the next few moments, I will make a mental image of myself as I am today. As I look at this mental image of myself, I will pay particular attention to my social health and well-being. As I look at this mental image of myself, and as I pay special attention to my social health and well-being, I will make note of my strengths and weaknesses. *[Pause for a few moments.]*

For the next few moments, I will make a mental image of myself as I would like to be. In terms of social well-being, I am focusing on how I would like to be in the future. I may think about the specific goals that I would like to achieve. This may take work, time, and patience, but I can achieve these goals. *[Pause for a few moments.]*

After this visualization is over, I will feel comfortable writing down specific goals that I would like to achieve in terms of my emotional well-being. I will also feel comfortable writing down my strengths and weaknesses in this area.

Distribute and Discuss: Handout—Social Well-Being Assessment

HANDOUT—SOCIAL WELL-BEING ASSESSMENT

The following people are important in my life:

In terms of my social well-being, my personal strengths include the following:

In terms of my social well-being, my personal weaknesses include the following:

In terms of my emotional well-being, my most important goal is:

In terms of reaching this goal, I must take the following steps:

Treatment of Dually Diagnosed Adolescents: The Individual Therapeutic Alliance Within a Day Treatment Model

Elizabeth Driscoll Jorgensen and Richard Salwen

1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

This chapter describes a day treatment model for adolescent drug abusers with a comorbid psychiatric disorder, with emphasis on those aspects of the individual counselor's relationship with the adolescent client specific to this program. Clinical techniques are described as they relate to the common treatment goals of motivating adolescent clients toward abstinence from alcohol and other drugs (AOD) and other self-destructive behaviors, preventing relapse, assisting adolescent clients in learning to recognize and tolerate strong affective states, and developing alternate coping mechanisms to drug abuse as a means of regulating these affective states. The importance of a sophisticated integration of psychodynamic clinical techniques with traditional chemical addiction or 12-step recovery model techniques is discussed as central to an effective working individual alliance with dually diagnosed adolescent clients within both group and individual treatments. Finally, a specific analysis of the interpersonal dynamics of the client-counselor relationship and the individual characteristics of the counselor is presented and discussed as central to the effectiveness of this model.

While biological and social factors play an important role in the etiology and maintenance of addictive behavior, it is the various psychological vulnerabilities that underlie the abuse of mood-altering drugs in adolescent clients that are central to the goals, structure, and function of the Center for Child and Adolescent Treatment Services (CCATS) Model. The uses of social reinforcement as a primary treatment technique, the referral of adolescent clients to 12-step meetings like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), and the use of traditional, educationally oriented counseling techniques and teaching of "the disease model" of alcoholism and addiction are discussed in depth in this chapter.

It is the authors' hypothesis that most of the adolescent clients treated within the CCATS Model have underlying deficits that have roots in the common experience of trauma, including pervasive sexual and physical abuse, loss, and inadequate parenting, in addition to the complicating factors of learning difficulties, parental alcoholism and drug abuse, and longstanding behavioral and emotional difficulties. These combined predisposing or premorbid psychological vulnerabilities can be characterized as consisting of various clusters of characterological deficits, deficits in self-structure, and patterns of maladaptive coping that have been longstanding and in fact may have been learned from earliest childhood as attempts by the child to adapt to a chaotic and unsafe emotional environment (Wood 1988). In this light, drug abuse is viewed as an effort to self-medicate (Khantzian et al. 1990).

1.1.1 Program Description. CCATS is a service of the Danbury Hospital, a teaching facility located in Danbury, CT. Adolescents 12 to 18 years old and their families make up the population being served. Adolescent clients presenting for treatment come from inpatient hospitalization; referrals from schools, court, and outpatient agencies; and family referrals. The CCATS Model serves both adolescent clients with a primary psychiatric disorder and those who are dually diagnosed—those with a coexisting psychiatric disorder and drug abuse and/or addiction disorder as diagnosed using DSM-IV criteria. The program description that follows focuses on the dual-diagnosis treatment track of the program, although many components of the program structure are the same for both clinical populations. Adolescent clients attend treatment for 4 hours a day, 5 days a week initially, and then transition to a 3-day-per-week program as they prepare for discharge and aftercare. Average length of stay is 6 to 8 weeks, with variations in length of stay determined by severity of symptom profile, psychosocial stressors, and global assessment of functioning upon intake and admission and during course of treatment. The involvement of family members or a foster parent or legal guardian is mandatory, as this involvement is viewed as essential to successful treatment outcome.

Adolescent clients must be willing to accept the structural requirements of the program, which include daily urine drug screening, random testing for blood alcohol level through the use of a breathalyzer, attendance at a minimum of three 12-step meetings (AA, NA, or Cocaine Anonymous [CA]) in the community outside of program time, and agreement to the disclosure of any relapse or serious violation of program rules or self-destructive behavior to their participating family members or legal guardians. Adolescent clients are also required to be enrolled in an educational program, usually a modified day at their own junior or senior high school, that could include tutorial or graduation equivalency diploma (GED) preparation.

Given this extensive level of behavioral expectations and limits around the amount of continued drug use while in treatment, candidates for this treatment approach must have at minimum a modest amount of motivation to establish abstinence. Motivation for sobriety is first assessed at the time of the initial evaluation and then on an ongoing basis throughout the course of treatment. Motivation may come from internal or external sources, but it is viewed as deriving from the adolescent client's distress. This distress may take the form of disappointment in self, depression, guilt, or fear of consequences (i.e., legal, familial, biological). Evidence of the nature and extent of this distress is actively solicited during the intake/assessment interview. Clinical staff make a conscious effort to maintain or heighten this distress in treatment, eventually working with the adolescent client to help shift his or her distress from being external to internal and from being punishment oriented toward being health oriented. Adolescent clients with a strong history of conduct-disordered behavior must be able to manage these behaviors in a less restrictive environment, as the CCATS Model uses only behavioral reinforcement techniques and "time out" in a nonrestricted environment for infractions of rules.

1.2 Goals and Objectives of Approach

Drug abuse and chemical addiction are viewed as primary disorders and are addressed as such. This clinical emphasis on the primacy of drug abuse disorders is based on the observation that adolescents actively engaged in regular use of mood-altering drugs have significant difficulty addressing any other treatment goal and in fact most often exhibit disinhibited expression of aggressive impulses and acting-out behaviors. Thus, the hierarchy of treatment goals, although individualized and specific to each adolescent, begins with the motivation of the adolescent toward abstinence from alcohol and other drugs and the decrease and ultimately the cessation of any use of mood-altering drugs. The secondary treatment goals are individualized but can be categorized as specific to the dominant psychiatric illness that is comorbid to drug abuse. For example, an adolescent client who presents with major depression disorder will have as treatment goals reduction and cessation of acute depressive symptoms. An adolescent client displaying conduct disorder with drug abuse will be encouraged to adopt treatment goals of cessation of the conduct-disordered behavior and development of alternative coping mechanisms to acting-out behaviors. In addition, the program focuses on the successful management of prominent self-destructive behaviors. Examples of typical behaviors observed in this population might be stealing, lying, school truancy, oppositional and defiant behaviors, sexual promiscuity, unnecessary physical risk taking, and social involvement with peers who are involved in drug use and antisocial behavior. The treatment philosophy emphasizes a reasoned, democratic, educational focus on the impact of self-defeating or self-destructive behaviors on the adolescent client's own personal goals and experience of conflict within interpersonal relationships and the experience of intrapsychic distress and anxiety.

Given the strong influence of the family's overall level of functioning, treatment goals always incorporate some measurable behavioral improvement in family functioning, from a decrease or cessation of intense conflict within the family to the referral of parents or siblings to their own treatment outside the program structure for psychiatric or drug abuse treatment, which is viewed as detrimental to the safety and psychological well-being of the adolescent client.

Finally, additional treatment goals in this approach are determined by the adolescent clients themselves. Examples of self-selected treatment goals include pursuing educational and vocational interests, exploring transferential phenomena, examining psychological conflicts, pursuing spirituality in a 12-step program or elsewhere, and exploring new or previous recreational pursuits or interests.

Lifestyle change is central to accomplishing most of the significant treatment goals within this model, most importantly the acceptance and adoption of an abstinent or "recovering" lifestyle through the positive influence of the prosocial culture of the treatment milieu and referral to meetings such as AA and NA.

1.3 Theoretical Rationale/Mechanism of Action

Within the Dynamic Integrated Treatment Model, the theoretical rationale is that drug abuse is an overdetermined phenomenon maintained as a behavior (despite significant negative consequences) because of its adaptive function as self-medicating underlying depression and overwhelming affective states (Bukstein et al. 1992; Fairbairn 1981; Khantzian 1978). Because of this assumption of the primary etiology of the behavior of drug abuse, all other aspects of the model are informed by the adolescent client's specific core issues related to loss, trauma, psychiatric illness, and related underlying vulnerabilities.

Within this framework, resistance to the establishment and maintenance of abstinence is seen as normal, predictable, and key to the establishment of long-term behavioral change. The mechanism of action within this model includes the provision of ego-supportive psychotherapy, as well as dynamically informed interpretation of an adolescent client's resistance and the underlying dynamics that block that client's ability to accept strategic or more behaviorally oriented counseling help. Furthermore, the mechanism of action is the use of the therapeutic alliance with the treatment staff to help adolescent clients consciously acknowledge, understand, and integrate aspects of their resistance to change and growth through the establishment of abstinence. Facilitating this process are various methods of behavioral and cognitive structure that are described in detail in this chapter.

1.4 Agent of Change

The adolescent client is viewed as the primary agent of change; however, the use of group affiliation with both the treatment milieu and 12-step fellowships outside of treatment serves as powerful motivation for adolescent clients, as do the individual relationships and alliances with the counselors within the program. Although these factors provide influence and structure, the emphasis is placed on the adolescent client's decision to absorb and use the structure, treatment, advice, and reinforcing aspects of these varied parts of the treatment. Any emphasis the adolescent client may make in attributing the causative factors of change as being outside of his or her self is carefully examined and interpreted. Counselors foster an environment where the adolescent client gains self-esteem through gradual acknowledgment of self-efficacy and internal locus of control in choosing to use the social and therapeutic support systems provided through the treatment center.

The language used by treatment staff, the behavioral expectations the staff have for adolescent clients, and the means through which behavioral limits are set and consequences given for the violation of behavioral limits make clear the underlying assumption of the treatment culture. Within this model, adolescent clients are viewed as responsible for their own behavior and ultimately responsible for the behavioral changes necessary for establishing and maintaining an abstinent or "recovery" lifestyle. While initial behavior change is acknowledged as difficult and painful at times by the staff's empathic feedback and explorations of ambivalence, the adolescent client is still viewed to be self-regulating and able to tolerate the difficulty inherent in change through use of appropriate social support and diversion techniques. The adolescent client is also encouraged to begin to recognize his or her abdication of responsibility outside of his or her self as central to the current difficulties.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

Central to the understanding of this treatment approach is a description of the conceptualization of drug abuse and dependence and their relationship to coexisting psychiatric disorders. Within this approach, drug use by adolescents is viewed as a social norm, whereas drug abuse and addiction are viewed as symptomatic of psychological vulnerabilities and an attempt to self-medicate affective states of sadness, anger, anxiety, frustration, and depressive symptoms. It is held within this model that depressive disorders and psychiatric symptoms predate the onset of drug abuse disorders in adolescents (Christie et al. 1988; Deykin et al. 1987; Newcombe et al. 1986).

The model of drug abuse and addiction as a biopsychosocial disease (Engel 1980) is a helpful conceptualization that incorporates all known components of etiology. This model is presented to adolescent clients within educationally focused treatment groups and appears to be both readily understood and intuitively accepted as an organizing conceptual framework for further exploration of an adolescent's individual involvement with chemicals, patterns of use, and family and social influences on use patterns.

In summary, drug abuse and chemical addiction are viewed as manifestations of underlying psychosocial vulnerabilities that may also be strongly influenced by biological, familial, and social factors that, once behaviorally established, present a relatively homogeneous pattern of symptoms and behavior. This pattern varies with respect to individual differences, level of drug use, and duration of drug abuse but does include behavioral deterioration, character disorganization (including a disinhibited expression of anger and aggressive impulses and an increase in acting-out behaviors), increased mental preoccupation with drug use and behaviors associated with the obtaining of and opportunity to use drugs, and finally the physical, mental, spiritual, and emotional deterioration of the individual. This model views drug abuse and chemical addiction in some instances as attempts by the individual to self-medicate overwhelming affect in the absence of alternative coping mechanisms.

2. CONTRAST TO OTHER COUNSELING APPROACHES

2.1 Most Similar Counseling Approaches

As previously described, the actual treatment format is varied and includes multiple modes of care. Common to the various modalities is the counselor's use of psychodynamic interpretation of resistance and the empathic exploration of ambivalence toward abstinence and treatment. This approach is most similar to the techniques of motivational interviewing (Miller and Rollnick 1991) and the transtheoretical approach of Prochaska and DiClemente (1984). The clinical techniques common to these approaches—including eliciting ambivalence, reframing, providing advice and empathic feedback, and using a directive yet nonconfrontational approach—are employed as powerful therapeutic tools during assessment, initiation, and active treatment phases. As in the Minnesota Model, adolescent clients' dishonest, manipulative, exploitive, or drug-using behaviors are directly confronted; however, this limit setting serves to allow the client the access to affect required for true change to occur through the disruption of the established pattern of projection of affect and acting out. Similar to traditional psychodynamic models, the counselor employs techniques of dynamic interpretation of resistance, transference, and acting-out episodes, albeit in the context of a treatment approach, which is actually quite directive and firm in setting limits with the adolescent client.

Borrowing heavily from the theoretical framework and resultant clinical techniques of the Motivational Interviewing Model, psychodynamic interpretation of resistance and acting out is added only in the context of a well-established individual relationship between client and counselor. This individual relationship of client and counselor is viewed as the central, unifying framework through which all treatment goals are formulated and implemented. The overall intellectual and clinical structure of the CCATS Model is in fact an eclectic formulation that integrates the compatible techniques of the models of stage change/transtheoretical; psychodynamic; and traditional, Minnesota Model, or 12-step recovery model techniques.

2.2 Most Dissimilar Counseling Approaches

The model differs most from a confrontational, traditional chemical addiction model where a client's resistance or ambivalence can be framed as a "lack of willingness to surrender" or as a symptom of denial or willfulness. Ambivalence within the integrated model is viewed as normal and predictable and as an important part of the process of initiating abstinence and maintaining sobriety. The use of empathic, reality-focused feedback on the part of the counselor is seen as aiding in the adolescent client's own self-exploration and ultimately self-motivation toward behavior change. This treatment approach is also differentiated from a traditional psychodynamic model in which the counselor declines an active, directive approach and the focus is solely on underlying dynamics and psychological vulnerabilities beneath drug abuse to the exclusion of direct questioning and exploration of the impact of drug use.

3. FORMAT

The combination of a variety of treatment modalities, including individual, group, and family therapy; educationally focused chemical addiction groups; use of therapeutic challenge (e.g., rock climbing, high ropes course, hiking); expressive arts psychotherapy; goal-setting groups; peer feedback groups; staff feedback groups; relaxation training; and psychopharmacology (when appropriate), create the essential treatment provided with the program. There is also an extensive use of behavior modification techniques within the structural framework of the program, including the use of a "level" status and privilege system and the extensive application of various reinforcement techniques including the celebration of adolescent clients' sobriety "anniversaries" of 30, 60, and 90 days clean and the use of a token system with the award of stickers depicting recovery-oriented "slogans" and sayings and peer and staff positive verbal feedback when adolescent clients have consistently refrained from the use of self-defeating or destructive behaviors and successfully used alternative coping mechanisms.

The encouragement of peer leadership and the nurturing and teaching of leadership skills are also essential aspects of the treatment format. Techniques include assigning responsibility to the senior members of the treatment community for orientation to treatment structure, rules and use of 12-step support groups and teaching of appropriate alternative coping mechanisms to drug use, and other acting-out behaviors through peers' disclosure of personal experiences with each other in group and informal settings. The counselors serve as guides for this process, but the adolescent clients themselves are delegated the responsibility for these tasks.

Comparison of the CCATS Model with other models.

	Traditional Psychodynamic Model	Dynamic Integrated Treatment Model	Disease Model of Alcoholism
Etiology	Psychological issues underlie all addiction; drug/ETOH use viewed as a symptom	Biopsychosocial model; drug abuse/addiction viewed as overdetermined phenomena	Biological basis for addiction; psychological factors seen as resulting from use of AOD

Treatment techniques	Primarily individual focus on dynamics of personality/long-term, insight-oriented therapy	Education/peer support; referral to 12-step programs; ego-supportive/dynamic psychotherapy; urine drug screens	Medical treatment; education/peer support; referral to 12-step programs with reinforcement for this participation; urine drug screens
Resistance	Interpreted in the transference	Explored, clarified, interpreted, confronted; transference to therapist/program and AA interpreted	Confronted; client seen as not willing to surrender or not willing to maintain sobriety if therapy fails
Treatment goals	Insight into intrapsychic and interpersonal dynamics resulting in cessation/reduction of symptoms	Abstinence from AOD; insight into dynamics of self and relationships; symptom relief; 12-step commitment/participation	Abstinence from AOD; 12-step participation and commitment

Adolescent clients' use of 12-step support groups is monitored through the creation of daily recovery goals that are behavior specific to attending meetings, associating with new "clean" peers, and acquiring an AA/NA or CA sponsor (a senior member of the recovery group who acts as a guide and provides individual support). Finally, bibliotherapy is also an important part of the structural format of the program. Adolescent clients are given books, pamphlets, and a personal recovery workbook that has worksheets and didactic materials on relapse prevention (RP), the biopsychosocial model of addiction, the self-medication hypothesis, effects of AOD on the body and mind, effective management and expression of anger, and various topics related to recovery from addiction. The completion of several of these required reading assignments and consistent attendance at 12-step meetings are included as key criteria (in addition to individualized treatment goals) to obtaining an increase in the client's level in the status system.

3.1 Modalities of Treatment

3.1.1 Individual Treatment. Individual sessions that last 20 to 30 minutes take place once a week. The importance of individual therapy is secondary to group treatment. In fact, the focus of individual treatment is most often on creating and updating the adolescent client's treatment plan, discussing the goals the adolescent client has chosen for group, and discussing family treatment and recovery for the week. Transference phenomena are interpreted, but the emphasis is on the adolescent client's effective use of group therapies and the establishment of a safe and supportive therapeutic alliance that the adolescent client can view as a central, unifying anchor within the context of an intensive, challenging, group-focused treatment structure. Although the relationship between the adolescent client and his or her counselor within the individual session is viewed as important, the adolescent client has been referred to the CCATS program specifically because of his or her need for a higher level of structure and containment than individual treatment can offer. As adolescent clients are for the most part in various stages of acting out their emotions and conflicts, the goal of the entire treatment program can be in essence described in a quotation from the program coordinator, "By the time adolescents can make good use of the individual session they are ready to be discharged from our program" (Walczak, personal communication, 1991).

3.1.2 Group Therapy. Adolescent clients participate in group psychotherapy sessions that last 1¼ hours three times a week. Group size ranges from four to eight members with two therapists serving as coleaders. Adolescent clients are expected to create a goal each week to serve as the structure and focus of their group work, although adolescent clients are actively encouraged to bring in any issue that is of importance, particularly those impacting their abstinence from alcohol or other drugs or urges to act out in self-destructive ways. The model of group therapy utilized within this model most closely resembles Modified Group Dynamic Psychotherapy (Khantzian et al. 1990), a technique pioneered at the Harvard Cocaine Recovery project with adult drug abusers. Specifically, traditional, expressive, ego-supportive psychotherapy is expanded to include direct exploration and interpretation of clients' difficulty managing affect, cravings for drugs, resistance to the use of social supports (e.g., 12-step participation), and the connection between the experience of intense affective states and the activation of cravings for AOD. The counselors serve to interpret group process, maintain behavioral boundaries, and provide feedback and interpretations. Important to the group therapy treatment is use of a separate feedback group in which group members give one another very specific feedback on their level of participation within the group therapy and their progress toward achieving sobriety tasks. This feedback is provided in a highly structured format, and peer feedback together with staff review of individual progress in treatment determine the adolescent clients' achievement of advancement within the levels system of the program.

3.1.3 Chemical Addiction Groups and Daily Recovery Goals. There are four specific chemical addiction groups per week, two of which focus specifically on education regarding the biopsychosocial model of addiction, RP: (1) history of, orientation to, and effective use of outside 12-step support groups; (2) physiological aspects of drug effects and addiction; (3) identification of affect and the use of cognitive and behavioral techniques for management of affect of anger as an alternative to acting out; and (4) topics generated by the adolescent clients' specific requests for information. Each adolescent client receives a recovery workbook created by the treatment staff. In it are worksheets addressing the above-named topics, literature describing various concepts in depth, and blank pages for adolescent clients to use in recording individual recovery goals and behavioral progress toward those goals. Daily recovery goals might include attending an AA or NA meeting, accomplishing a recovery reading assignment, or terminating an unhealthy peer relationship or establishing a new, supportive one. Each goal is chosen by the adolescent client, and he or she receives verbal reinforcement and feedback from peers and staff along with a visual reinforcement on a goals board that is prominently displayed within the community. Adolescent clients also process cravings for AOD, "relapse dreams," and RP plans within these groups.

3.1.4 Other Treatment Modalities. Although a description of the other treatment modalities employed in the treatment of dually diagnosed adolescent clients is beyond the scope of this chapter, the importance of these other modalities must be emphasized. Other approaches to treatment utilized at CCATS include family therapy, expressive arts, and pharmacotherapies, as well as activities like the therapeutic challenge program. Family therapy stresses as primary goals developing a collaborative relationship with the adolescent client's parents, recognizing the familial patterns of denial and enabling, and identifying the addictions of other family members.

The expressive arts program provides a means of accessing feelings that adolescent clients may otherwise deny, suppress, or lack words to describe. The therapeutic wilderness challenge program is used to promote group cohesiveness and to aid adolescent clients in confronting fears rather than avoiding them by using drugs or other maladaptive coping mechanisms. Finally, given CCATS' affinity for the self-medicating hypothesis as a precipitant for drug abuse, pharmacotherapy is often used as an adjunct to treatment to address underlying disorders that are frequently depressive in nature.

3.2 Ideal Treatment Setting

The CCATS Model was specifically designed for a day treatment or partial hospital setting. The program provides integrative case management to link the educational programming that adolescent clients receive each morning through their local school system with their clinical treatment and 12-step program work.

3.3 Duration of Treatment

The average length of stay in the CCATS program is 12 to 16 weeks, with actual length varying according to clinical need. Treatment plans are reviewed twice a week to discuss and document the adolescent client's progress toward achieving treatment goals and discharge planning in relation to the adolescent client's accomplishments, or the clear indication that the adolescent client needs a higher level of treatment or change in treatment plan because of noncompliance or an increase in symptoms or behavioral difficulties.

3.4 Compatibility With Other Treatments

As noted in the description of the program detailed previously, other therapeutic modalities, such as pharmacotherapy, family therapy, and expressive arts therapy, are considered to be not only compatible with but also essential to the success of treatment.

3.5 Role of Self-Help Programs

As previously discussed, special emphasis is placed on participation in AA/NA or CA for drug-abusing clients. Adolescent clients are informed before beginning treatment that they will be expected to attend at least three 12-step meetings a week outside of program hours. Again, their participation is encouraged through peer feedback and the behavioral techniques described earlier. Adolescent clients who have a drug-abusing parent are educated about Alateen groups, and parents of adolescent clients in the dual-diagnosis program are themselves referred to Al-Anon for additional support and education regarding self-care, boundary setting, and help in ending enabling behaviors. Essentially, adolescents readily attend 12-step meetings and use the groups on a variety of levels, including social support and normal ego-supportive socializing; for identifying positive mentors, role models, and parental figures; for educational help, support, and advice in remaining sober; and for enjoyment and stimulation. Adolescent clients are encouraged to obtain an AA/NA or CA sponsor, that is, a person with long-term sobriety who acts as a guide and who in general will be available for support 24 hours a day during the adolescent client's active treatment and after discharge, thus providing continuity and direction.

For many adolescent clients, the 12-step programs serve as a surrogate family, where their original family system may be chaotic, devaluing, or nonexistent. The authors have witnessed many adolescent clients who were removed from their families and in various stages of foster care or surrogate care were able to use the 12-step programs as an effective means of obtaining nurture and structure.

Within the context of CCATS' emphasis on the use of 12-step meetings, each adolescent client is encouraged to embrace a conceptualization of these groups and the spiritual focus of the 12-step philosophy that reflects his or her own personal values, spiritual orientation, and individual preferences. The adolescent client is continually encouraged to examine and to express his or her ambivalence toward the 12-step programs without fear of consequence or reflection in privileges or status in the program. It is of clinical interest to note that in this environment, one that allows and acknowledges the importance of ambivalent feelings and their expression, there is very little behavioral resistance to 12-step attendance.

4. COUNSELOR CHARACTERISTICS AND TRAINING

4.1 Educational Requirements

The general educational requirements of the staff include an advanced degree in social work, expressive arts therapy, psychology, nursing, or counseling and specific continuing education and inservice training in chemical addiction and drug abuse treatment. A minimum of 3 years of clinical experience with adolescents is required, as is ongoing clinical supervision.

The clinical coordinator of the Adolescent Dual-Diagnosis Service is a certified alcohol and other drug abuse counselor with 8 years of psychiatric clinical experience.

4.2 Training, Credentials, and Experience Required

Particular emphasis on the use of dynamic examination of the therapist's own countertransferential experiences and reactions to clients' transference is an important aspect of clinical supervision, which occurs both individually between the counselor and a senior clinical supervisor and in the context of the coleader relationship in group therapy.

Counselors within this model are required to have a high level of understanding and acceptance of the validity and importance of psychodynamic techniques, along with a willingness to be introspective and to a certain degree able to acknowledge unresolved personal conflicts, which may be found to block clinical sensitivities within the present. Because of the eclectic nature of the various treatment modalities employed within this model, counselors must be skilled and cross-trained in various modalities and techniques and must have the personal characteristics of flexibility and intellectual fluidity to function in multiple roles.

4.3 Counselor's Recovery Status

The status of a counselor as being in recovery from alcoholism or addiction or having firsthand knowledge of Al-Anon recovery is not essential to being effective. However, the intricacies of experience awarded through an individual's participation in his or her own recovery program can probably not be equal to a solely intellectual pursuit of the same knowledge. Counselors within this treatment program who are in recovery from addiction or coaddiction do not participate in free self-disclosure of their status and most specifically refrain from the disclosure of significant information regarding their history of drug use or other significant personal history. Inevitable direct questions from adolescent clients regarding both the counselor's recovery status and specific details of the counselor's history of drug abuse or previous treatment experience are usually answered interpretively, although the individual counselor is free to disclose his or her status as a recovering person. It appears that adolescent clients react favorably to recovery-oriented feedback from nonrecovering staff members; however, the level of knowledge, comfort, and conviction a counselor has regarding the content of educational material or directive or interpretive feedback may be the key indicator of the effectiveness of the counselor's impact. In short, for a counselor to impart effectively the philosophy of a world view that holds central the belief in using a power greater than one's self, either socially or through spiritual means, he or she must have a similar personal investment in the value of this world view. Similar to the means through which self-esteem is subtly and consistently imparted to a child through the actions and words of a healthy, caring parent, the adolescent client will "catch" the value of the 12-

step philosophy through the individual relationship and teaching of a counselor who lives by his or her espoused beliefs.

4.4 Ideal Personal Characteristics of Counselor

The personal characteristics most ideally suited for this treatment approach include the qualities of warmth, genuineness, empathy, clear personal boundaries, and a high degree of self-awareness and psychological mindedness. In addition, attributes of flexibility and humor and the ability to set firm behavioral limits in a nonjudgmental and nonpunitive manner are very useful. The carefully restrained use of personal charisma and humor aids the counselor in motivating adolescent clients and engaging resistant clients in a working therapeutic alliance. However, the counselor must always be aware of the extent to which the use of these particular characteristics may be in the service of gratifying his or her own narcissistic needs. Again, it is a function of the carefully structured supervision inherent in this clinical model that would aid in the most effective and nonmanipulative use of charisma and humor with adolescent clients.

4.5 Counselor's Behaviors Prescribed

A skilled counselor must be able to maintain a sense of personal integrity and a strong sense of self to be able to deflect, tolerate, control, and interpret accurately the projected identification and projection of rage and self-loathing typical of adolescent clients with borderline or narcissistic features.

Psychologically oriented self-awareness and clear personal boundaries also aid the counselor in minimizing his or her acting out of unresolved dynamic conflicts and having his or her own insufficient narcissistic reserves gratified within the therapeutic relationship through idealization and misuse of power. The same personal strengths are again called into play when a counselor must refrain from failing to set appropriate limits, again in the service of regulating his or her own internal narcissistic stores. When a counselor sets a limit with an adolescent client who is acting out, the client may attack the counselor verbally in an attempt to avoid experiencing affect. A counselor who struggles with maintenance of self-esteem will inevitably err when setting limits. The use of careful clinical supervision can aid in the continuous self-examination of these potential vulnerabilities.

Although the personal characteristic of flexibility is difficult to define operationally, it is clearly a necessary personal attribute when working closely with adolescent clients who act out through means of verbal abuse, physical aggression, and self-destructive, self-injurious means. Flexibility is key in avoiding the ever-ready opportunity to engage the adolescent client in subtle or overt power struggles, program rules, personal responsibility for behavior, or a variety of clinically relevant topics.

4.6 Counselor's Behaviors Proscribed

Behaviors proscribed within this approach are those related to direct, unyielding confrontation of resistance or passive acceptance by the adolescent client or the adaptation of a nondirective stance toward the adolescent client's resistance, acting out, or suspected drug abuse. The counselor who is in his or her own recovery is also prevented from relating details of his or her former drug use and specifics of his or her own personal recovery, as it is viewed as deflecting the adolescent client's focus from his or her own treatment. Counselors should refer adolescent clients to 12-step meetings where they will be exposed to socializing and self-disclosure of other recovering individuals. The counselor, while not rigidly refraining from any self-disclosure, must remain a neutral object for the adolescent client's transference.

Other proscribed behaviors include using any statements, interventions, or techniques that involve humiliating, shocking, or pressuring the adolescent client to behave in ways that violate his or her free will and personal integrity. The counselor should never use derogatory language, accuse a client of character defects, demand that a client "surrender" or "work the steps," or use any other such controlling behavior. The use of shaming techniques constitutes emotional abuse, not treatment. The counselor also is prohibited from colluding with an adolescent client's active relapse or possible drug use by refraining from holding him or her responsible for his or her own recovery and behavior or by withholding such information from other group members.

4.7 Recommended Supervision

Coleaders meet on a regular weekly basis (with a senior clinical supervisor) to examine the group process and aspects of counselors' relationships as they relate to countertransferential feelings and individual perspectives and feedback on the actual techniques employed by coleaders during the group. These techniques were implemented and supervised by the initial creator of the program, Dr. Richard Salwen, who asserts that "The quality of the clinical work is dependent on the quality of the clinical supervision" (Salwen, personal communication, 1991).

5. CLIENT-COUNSELOR RELATIONSHIP

5.1 What Is the Counselor's Role?

Within this model the counselor has multiple roles, serving as teacher, guide, consultant, therapist, and coach to the adolescent client in a journey of self-knowledge. The counselor is seen initially serving as a charismatic coach or directive guide as the adolescent client becomes accustomed to the boundaries and limits of treatment, establishes rapport with staff and peers within the treatment program, and experiences initial success in establishing minimal treatment goals within the group setting. Even given the role of the counselor as guide and initial leader, within this treatment approach the adolescent client is consistently reminded that he or she is the central agent of change within his or her own life.

5.2 Who Talks More?

The adolescent client generally talks more during group and individual sessions. There are exceptions, however, during didactic presentations and in the earliest phase of treatment initiation. Here the counselor may choose to be quite directive and impart general information and teaching regarding program rules, structure, and expectations, both in the service of communication of this information and in the establishment of an initial rapport or relationship with the adolescent client.

5.3 How Directive Is the Counselor?

The counselor is quite directive, and the limits and boundaries of the CCATS structure serve as a vehicle to impart structure and limits to the adolescent client. Within the individual relationship, the counselor strives to be directive without committing the errors of control or disengagement described earlier. Adolescent clients who idealize the counselor and request opinions and direct advice are asked to examine their own feelings and to express their own thoughts or request feedback from the counselor or the group to diffuse the role of counselor as omnipotent and to encourage and foster the strengths of the other members of the group and the group process itself.

5.4 Therapeutic Alliance

The quality of the therapeutic alliance (TA) between the counselor and the adolescent client is the most essential aspect of treatment, and great care is taken by the counselor to create a safe and predictable holding environment for the client's concerns, affect, and behaviors. The counselor does so by creating clear and consistent boundaries within the individual relationship. Thus, the counselor remains a stable, dependable presence with the adolescent client whenever possible. The counselor extends this sensitivity to the individual relationship in various ways, including anticipating a client's possible reactions to events such as the counselor's vacations, illness, or other absences from the treatment milieu.

The counselor also seeks to develop a strong initial alliance with the adolescent client through displays of active interest in the client's experience of treatment and recovery (i.e., direct questions about symptoms, level of participation in self-care, attendance at 12-step meetings). Humor and interpretation of resistance are used in place of direct confrontation, and the alliance is built and sustained by each interaction, in which the counselor demonstrates an ongoing interpretive sensitivity. The TA is also built through appropriate and consistent limit setting, as it is the underlying assumption that the adolescent client who has difficulty with self-regulating impulses feels comforted by external limit setting and may use this aspect of TA to internalize limits and improve self-regulation of impulses and affect.

A TA where the adolescent client has a strong negative transference, or one that is initially weak, is managed interpretively, and the client is encouraged to discuss his or her resistance openly. The counselor's goal is to strengthen the TA through interpretation of the client's transference, and the very act of accepting the client's experience without judgment often serves to enhance the working alliance.

6. TARGET POPULATIONS

6.1 Clients Best Suited for This Counseling Approach

The CCATS Model is specifically designed for a dually diagnosed adolescent population; however, the aspects of the client-counselor relationship are applicable for use with any population. The program has been successfully employed with clients who have abused a wide range of drugs, including primarily alcohol, marijuana, hallucinogens, heroin, amphetamines, and inhalants.

6.2 Clients Poorly Suited for This Counseling Approach

Individuals who are not well matched to this treatment approach include those adolescents with extreme behavioral problems (e.g., frequent violent outbursts), those with no desire to initiate or maintain abstinence from use of mood-altering drugs, and those with pervasive intellectual or physical disabilities. As the integration of 12-step-oriented treatment and psychodynamic treatment techniques demands that an adolescent client be able to use abstract thinking, the client must have intellectual functioning in the low average to average range. It does not appear that adolescent clients need to have reached formal operations to benefit from treatment, and in fact many adolescent clients are observed progressing from concrete operations to more formal, abstract thinking ability while exposed to the highly abstract and stimulating communication that occurs within the treatment milieu. Adolescent clients who have pervasive learning disabilities or who are significantly impaired organically will also be poorly suited to this approach and would require a modified program, as well as extensive use of specialized cognitive retraining and rehabilitation services, in addition to the treatment.

7. ASSESSMENT

The scope of this chapter does not allow for a thorough description of the assessment techniques employed within this counseling model; however, a brief description of the structure and clinical philosophy of the assessment process serves to illustrate further the relationship of adolescent client and counselor. Assessment within this model is viewed as the first stage of treatment and the data collection as equal to the establishment of the therapeutic alliance and the enculturation of the adolescent client to the treatment process through basic teaching of boundaries, expectations, and language commonly used in treatment. As many adolescent clients will be experiencing a psychiatric and drug abuse evaluation for the first time, special consideration is made to proceed slowly and with empathy to the anxiety, fear, and affect of the adolescent client and his or her family members. The adolescent client is assessed for drug abuse by conducting a urine drug screen, by using semistructured clinical interviews, and by performing standardized psychological testing employing the Personal Experiences Inventory and the Reynolds Adolescent Depression Scale. The counselor remains aware that an adolescent who is a drug abuser and who is chemically dependent will consciously and unconsciously minimize the extent of his or her drug use and its negative behavioral consequences during the assessment process. For this reason, careful attention is paid to collateral sources of information (e.g., family members, probation officers, school personnel) when they are available.

The adolescent client's drug abuse history is considered within the context of a psychosocial history with an emphasis on the following: trauma, family functioning and dynamics, family history of drug abuse and psychiatric illness, involvement with the law, spiritual life, and present level of motivation toward abstinence. The counselor is seen as ideally working in partnership with the adolescent client and his or her family in establishing a working alliance, obtaining information, providing feedback, and formulating a treatment plan based on the data obtained.

8. SESSION FORMAT AND CONTENT

The format for treatment sessions varies with regard to the modality of treatment within the overall treatment model.

8.1 Format for a Typical Session

A typical chemical addiction group begins with participants discussing their daily sobriety goals and receiving peer feedback for either their accomplishments or resistance to completing their self-established goal. The format of the group then shifts to an interactive/didactic style, where the counselor presents information on such topics as RP, use of 12-step support groups, and the first three steps of the 12 steps. The counselor uses circular questioning, making participants answer open-ended questions on the information as it relates to their own experience and recovery, or the counselor may elicit resistant group members to describe their ambivalent feelings. Group process generally addresses resistance in the most effective manner, and the counselor takes a back seat to the natural process of the group except to limit inappropriate behavior, aggressive expressions of rage, and so forth. Group members also set behavioral limits for themselves and are particularly adept at recognizing warning signs of relapse in one another. The group ends with a brief commentary by the group leaders on the topic discussed and the process of the group.

A typical group session might involve a discussion around the use of selective cognitive schemata, either to "compare in" to other people in AA, treatment groups, or in general, or the more common cognitive schemata of using judgmental self-statements that separate one's experience from others ("comparing out"). The interactive lecture focuses on the self-statements made when choosing to distance one's self and feel either superior or inferior in experience or unique in terms of affect, fears, and so on (comparing out) versus the self-statement made when attempting to feel connected to and empathizing with another's experience, feelings, or opinions (comparing in). Adolescent clients are asked to think of their most typical self-talk patterns, particularly as they relate to their level of honesty, vulnerability, and self-disclosure of drug cravings, affect, ambivalence and fears in the treatment setting and in the 12-step meetings. Sessions are semistructured and focus on the here-and-now group process taking precedent over a structured lecture format. The importance of education is not deemphasized in this context; however, the counselor's role as teacher is complementary to his or her role as supportive and interactive psychotherapist.

8.2 Several Typical Session Topics or Themes

Treatment sessions typically focus on topic areas directly related to adolescent clients' drug abuse and its relationship to other symptoms and behavioral consequences. Within this broad heading frequent topics include:

- Self-medicating aspects of drug use and the relationship of depressive symptoms to drug use (Khantzian et al. 1990).

  Within this topic area, adolescent clients discuss not only their use of drugs but also related self-destructive behaviors that can be seen as self-medicating (e.g., self-mutilating behaviors, sexual acting out, shoplifting, acting-out anger). Clients gain insight into the interrelated aspects of all these behaviors as attempts to self-manage and medicate overwhelming affect. Alternative coping mechanisms are introduced by the counselor through questioning of clients regarding their own strengths and abilities used to avoid these behaviors.

- Creating a "chemical history" or truthful description of all mood-altering drugs used, as well as positive aspects of use and negative consequences related to use.

  This topic allows for the enhancement of cognitive dissonance related to drug use as a coping mechanism. In particular, adolescent clients are encouraged to describe and acknowledge the positive and, at times, adaptive aspects of their previous drug abuse as a means toward further insight into the self-medicating aspects of use, as well as to avoid the "splitting off" of the good aspects of drug use from the therapeutic alliance.

- Discussing orientation and resistance to 12-step attendance.

  Adolescent clients are given structured behavioral expectations for 12-step attendance that are nonnegotiable as part of treatment; however, the clients' ambivalence and resistance to these aspects of treatment are not only anticipated but also elicited in group and individual sessions. The underlying assumption of the counselor is that adolescent clients' fears, anger, or defiance of this aspect of treatment are significant to underlying vulnerabilities of self and fears of the unknown aspects of recovery. Attending 12-step meetings is seen as an educational experience, and clients are not forced to adapt any of the philosophical or social aspects of these meetings. Thus, resistance can be seen as emotionally based. (See section 8.3 for a brief session description that illustrates this topic in a session with a resistant adolescent.)

- Identifying and understanding relapse triggers and how to manage urges to use drugs.

  Within this topic area, adolescent clients disclose and discuss their relapse experiences and share alternative coping mechanisms.

- Relating family issues to drug abuse and psychiatric symptoms.

  Adolescent clients create a genogram with a staff member or discuss family history of drug use, depression, and other relative behaviors. The research supporting the genetic factors related to psychiatric illnesses and drug abuse is presented. Clients are encouraged to see the patterns of strengths and vulnerabilities within their families and in doing so acknowledge and discuss their own struggles to separate from family patterns.

8.3 Session Structure

Within the Dynamic Integrated Treatment Model, group sessions and the focus of treatment goals are highly structured in order to elicit clients' resistance and help them move toward behavioral change through resolution of the underlying issues creating resistance. Each day in treatment, adolescent clients are asked to create a specific treatment goal relative to their establishment of abstinence, AA/NA attendance, family issues, and so forth. These goals are reviewed within a community discussion that includes all staff and clients; the client then continues work on these goals throughout the remaining three therapeutic groups of the day.

The interaction between counselor and client within this model is relatively unstructured as the counselor follows the process and content of what the client brings into the group or individual session vis a vis treatment goals. The counselor creates structure within the session by maintaining an interpretive role that helps guide the client closer to the underlying issues of psychological vulnerabilities and to the dynamic issues of loyalty to parents and important others and conflicts regarding the client's movement toward health.

Following is a brief transcript of a session with a dually diagnosed 13-year-old girl that clearly illustrates how the counselor maintains this interpretive structure and position while following the client's lead with regard to content and process of the session. This adolescent client's daily goal was to discuss attending AA meetings and talk about her feelings regarding this attendance. Of note is that the counselor was aware of the adolescent client's family history of having an alcoholic mother and a sibling who was addicted to drugs. Both these family members were still actively using drugs at the time of this young woman's treatment. Also, this young woman had experienced the death of a younger brother 5 years previous to her treatment.

Client: *I am not going to any AA meetings. This is stupid, and there is no way I am going, so don't even bother with the psychobabble.*

Counselor: *Something really makes you angry about the rule about going to meetings. I wonder what really gets to you about that?*

Client: *I told you, it is bulls--t and I am not going. I hate this place.*

Counselor: *Seeing how upset you are I wonder what it might be like being asked to go to AA to take care of yourself when your Mom and your brother are still using. No one is helping them. It's really not fair that you have to learn to get well and take care of yourself.*

Client (softening): *Yeah. Why don't they have to go? I am only 13!*

Counselor: *It would be my dream for you that your whole family got healthy together.* (Pause. Client nods.) *But it looks like you might have to have the courage to be the first one. You're right, it's not fair.*

Client (tearful): *It's so hard. No one gets it.*

Counselor: *Your Mom and brother don't get it right now, you're right. It must be really hard to trust what the staff here says over them right now.*

Client (nods, still tearful): *I wish they would come to meetings with me.*

Counselor: *That would be great.* (Pause.) *Will you consider going to the meetings here with some of your peers and continue talking about all the things you just said to me?*

Client: *Yeah, I guess for now.*

In this brief transcript, the adolescent client's unconscious resistance issues are helped to come into conscious awareness by the counselor's sensitive integration of underlying dynamic issues into the feedback to the adolescent. The client, through setting the goal of AA attendance, was able to present her unconscious resistance and move toward separation from unhealthy family members and greater self-care through the exploration of this resistance. This client was ultimately able to maintain sobriety, attend AA, and experience significant improvement in her self-care both physically and psychologically.

In this model, resistance is always seen as meaningful. The counselor not only structures feedback toward the issue of 12-step attendance and the client's intense resistance to this but also broadens the topic to integrate the threatening and overwhelming affect relating to the client's resistance to self-care.

8.4 Strategies for Dealing With Common Clinical Problems

The issues of denial, resistance, lateness, and missed appointments are viewed not so much as clinical problems but as various manifestations of the adolescent client's ambivalence toward abstinence, recovery, and emotional healing. Within this counseling style, these issues are seen not only as normal and predictable but also as inevitable and valuable. Behaviorally, adolescent clients are given limits and are punished for lateness or absences through a drop in their "level" status and a discussion of their acting out within the community. Adolescent clients are encouraged to examine their ambivalent behavior and to formulate their own hypothesis regarding its nature, cause, and solution.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

The more subtle issues of denial and resistance are dealt with in the clinical context of each adolescent client's progress in treatment. Again, he or she is encouraged to explore the ambivalent feelings rather than to deny, repress, or distort personal expression in order to conform to the expectations of the counselor.

8.6 Strategies for Dealing With Crises

The CCATS Model has built into it policies and procedures for dealing with crises. Included in the services is access to a 24-hour crisis intervention service through the hospital for adolescent clients and their families. Adolescent clients can also be hospitalized briefly in the inpatient psychiatric unit when they are experiencing acute depressive symptoms and active or passive suicidal ideation. The crisis experience is always integrated into the adolescent's relationship with his or her individual counselor and within the CCATS milieu.

8.7 Counselor's Response to Slips and Relapses

The response of the counselor to an adolescent client's slips or relapses is considered a critical aspect of both the overall treatment philosophy and, more centrally, the individual relationship between the counselor and his or her client. The counselor responds in an empathic manner, helping the adolescent client explore the precursors to the relapse and allowing him or her the opportunity to explore feelings of ambivalence toward abstinence and the full range of feelings toward the relapse experience. The adolescent client often views the relapse experience as pivotal to his or her ability to commit to abstinence after exploring the actual impact of the drug use on his or her behavior, feelings, and relationships. The counselor frames the slip as an opportunity to learn and to commit to abstinence, without minimizing the impact or seriousness of the potential to relapse in the future.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

The involvement of family members or guardians, as described previously, is considered essential to the adolescent client's success. A unique structure of the CCATS Model is the inclusion of the adolescent's AA sponsor in treatment. Adolescent clients are required to obtain an AA or NA sponsor within the first weeks of treatment and in turn to invite their sponsor to participate in a conjoint meeting with their parents at home and with their primary counselor during program hours. This involvement ensures that adolescent clients obtain a sponsor and also communicates the importance that the clinical staff imparts to the use of outside supportive relationships in the 12-step programs to the ongoing sobriety and emotional well-being of clients. An indirect message is also communicated to the adolescent client within the individual client-counselor relationship through this involvement: the fact that the counselor can tolerate the caring and affectionate relationship of the adolescent with other supportive adults. The healing nature of this posture is imperative for adolescents who have had parents or caregivers with borderline or narcissistic pathology.

10. DISCUSSION AND CONCLUSION

For treatment to have longstanding impact on adolescents who suffer from comorbid psychiatric and drug abuse disorders, the adolescent client's longstanding and overdetermined psychological vulnerabilities must be addressed. Chemical addiction and drug abuse should be addressed through a structured psychoeducational treatment format that incorporates the techniques of psychodynamic interpretation of resistance, the acceptance of ambivalence and relapse as developmental aspects of the recovery process, and the referral of clients to 12-step support groups. Within the context of a supportive and empathic individual relationship with the adolescent client, the uncovering and reexperiencing of repressed affect that appears to predate and coexist with chemical addiction is achieved through the setting of firm, consistent, and reliable limits and boundaries that include reframing and interpreting the adolescent client's resistance to experience affect. For adolescents who therefore almost exclusively use maladaptive coping mechanisms of an externalized nature (e.g., drug abuse, conduct-disordered behavior), the treatment goal of developing the alternative coping mechanisms of identifying, experiencing, tolerating, and verbalizing affective stages of anger, frustration, sadness, and disappointment becomes a focus of treatment. This focus on affective "recovery" is accomplished only within the context of a trusting and valued individual relationship, where the client suspends (if only momentarily at first) his or her complete reliance on personal defensive postures. Through this trusting relationship, and the suspension of defensive postures, the adolescent client can begin to learn and rehearse the world view described within the 12 steps of AA, where the client, after admitting the futility of a delusion of omnipotent control of reality, comes to believe he or she is not alone and can rely on others for care and nurturing to withstand considerable psychiatric distress without acting out in an effort to discharge this affect. The counselor must receive ongoing psychodynamically oriented clinical supervision to maintain the level of introspection and sensitivity required of the fluid role expectations of this model and the intense emotional requirements of firm and consistent limit setting with clients who devalue, use physical and verbal acting out, and resist the expression of affect other than anger.

Although it is this individual relationship that is viewed as the context through which many aspects of behavior change are attributed, the structure and content of group experiences are designed to allow clients to explore ambivalence and motivation and gain insight into the impact of the use of drugs on their lives. A cognitive, behavioral focus on establishing abstinence sets the stage for further exploration of the symptoms related to the assumed causative factors of drug addiction. Although these underlying causative factors are seen as secondary to the establishment of initial abstinence, the long-term maintenance of abstinence is seen as directly related to the ability of the adolescent client to accept responsibility for self-care; to develop alternative, more mature defense mechanisms; and to begin the lifelong process of affective expression and the establishment of meaningful intimate relationships with others. A phrase used to teach this truth to the adolescent client is often repeated within the treatment milieu, "To stay clean, you must learn to replace your drug of choice with human relationships."

In the context of a warm and supportive relationship between counselor and client, all goals and objectives of treatment are interpreted and created. The counselor becomes the "good-enough" parent who serves as teacher, historian, parent, coach, and guide to the adolescent client as he or she experiences the affect long buried beneath the previously functional defense of chemical abuse.

For the adolescent client to release his or her dependence on the powerful, self-medicating aspects of chemical abuse, the counselor must impart both directly and indirectly the message that human relationships can be hopeful, loving, and supportive. Through exploration of the inevitable disappointments within the individual therapeutic relationship, the adolescent client can learn that the intense affect that may be experienced at these times, transferentially evoking injuries sustained in the context of primary relationships with significant others, can be managed within a world view of ultimate faith in the value of each individual's capacity to give and receive caring and love.

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Description of an Addiction Counseling Approach

Delinda Mercer

1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

Addiction counseling addresses the symptoms of drug addiction and related areas of impaired functioning and the content and structure of the client's ongoing recovery program. This model of addiction counseling is a time-limited approach that focuses on behavioral change, 12-step ideology and tools for recovery, and self-help participation.

1.2 Goals and Objectives of Approach

The primary goal of addiction counseling is to help the client achieve and maintain abstinence from addictive chemicals and behaviors. The secondary goal is to help the client recover from the damage the addiction has done to the client's life.

1.3 Theoretical Rationale/Mechanism of Action

Addiction counseling works by first helping the client recognize the existence of a problem and the associated irrational thinking. Next, the client is encouraged to achieve and maintain abstinence and then develop the necessary psychosocial skills and spiritual development to continue in recovery lifelong.

1.4 Agent of Change

Within this addiction counseling model, the agent of change is the client. The client must take responsibility for working a program of recovery. However, although recovery is ultimately the client's task, he or she is encouraged to get a great deal of support from others such as the client's counselors, treatment staff, sponsor, drug-free or recovering peers, and family members.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

Drug abuse is thought to be a multidetermined, maladaptive way of coping with life problems that often becomes habitual and leads to a progressive deterioration in life circumstance. Habituation of drug abuse is addiction, seen as a disease in its own right, which damages the addict physically, mentally, and spiritually. Causation is not a prominent focus of treatment.

2. CONTRAST TO OTHER COUNSELING APPROACHES

2.1 Most Similar Counseling Approaches

Because this model of addiction counseling is time limited and focuses on behavioral change and 12-step ideology and participation, the most similar approaches would be short-term cognitive behavioral therapy to treat addiction or short-term counseling based on the 12-step approach to recovery.

2.2 Most Dissimilar Counseling Approaches

The most dissimilar approaches are the traditional approach as provided in a therapeutic community, not because of the content that might be similar but because of the format that would probably be more punitive and confrontational and less respectful of the client, and the open-ended, nondirective psychotherapy approach.

3. FORMAT

3.1 Modalities of Treatment

This counseling model has been developed for use in individual and group contexts.

3.2 Ideal Treatment Setting

This model was developed for use as part of an outpatient addiction treatment program. It could, however, be adapted readily for use in an inpatient program with the following modification: It is planned to span 6 months, and usually inpatient treatment is 4 to 10 days for detoxification and up to 28 days for rehabilitation. The model could be altered to offer sessions more frequently over a shorter period of time.

3.3 Duration of Treatment

This model is progressive and time limited; the active treatment phase runs 6 months, and there are followup sessions of up to 1 year. For individual treatment, there are two sessions a week for 3 months followed by one session a week for 3 months. The followup phase involves one session every other week for 3 months followed by one session a month for 3 months.

The group component of treatment is twice a week for 2 months and then once a week for 4 months. An advanced recovery group for post-6-month clients would undoubtedly be helpful but was not developed as part of these treatment manuals.

Individual sessions should run from 45 to 50 minutes; groups run 1½ hours, including about 15 minutes for collection of urine and breathalyzer data.

3.4 Compatibility With Other Treatments

These manuals for addiction counseling, as developed for individual and group counseling, were designed to be components in a more comprehensive treatment program. Combined with detoxification, initial medical and psychosocial assessments, and ongoing participation in a self-help program, individual and group addiction counseling can make a complete treatment package: However, these treatments may also be used in conjunction with pharmacotherapy, other medical therapies (e.g., acupuncture), family or couples therapy, or professional psychotherapy.

3.5 Role of Self-Help Programs

Participation in a self-help program is considered an extremely valuable aid to recovery. It helps recovering individuals develop a social support network outside of their treatment program, teaches the skills needed to recover, and helps clients take responsibility for their own recovery.

In addition to encouraging clients to attend self-help groups at least three times a week and to locate a sponsor, the addiction counseling program educates clients about the 12-step program and incorporates many of its concepts into the content of the counseling. Breaking through denial; staying away from negative people, places, and things; taking a personal inventory; working on character defects; and spirituality in recovery are among the concepts addressed within the content of the counseling sessions.

As to 12-step versus other programs, participation in any legitimate self-help program the client gravitates toward, such as Rational Recovery and Women for Sobriety, is supported. However, because the 12-step approach to recovery is well known, more widely available, and has been an integral part of many addicts' recovery programs, it is this approach in addiction counseling that is drawn on.

4. COUNSELOR CHARACTERISTICS AND TRAINING

4.1 Educational Requirements

For purposes of the research protocol for which this treatment was designed, the educational requirement for group or individual addiction counselor was no higher than a master's degree. The range of education is associate's to master's degree in a human services field.

4.2 Training, Credentials, and Experience Required

Counselors must have a minimum of 3 years' experience in addiction counseling and must be knowledgeable of and use the 12-step model. Group counselors must also have experience in leading groups. The professional credentials for addiction counselors (in Pennsylvania, associate addiction counselor [A.A.C.] and certified addiction counselor [C.A.C.]) are encouraged but not required. Counselors often become credentialed after having worked with institutions for a period of time.

4.3 Counselor's Recovery Status

Many counselors in this field are either in recovery themselves or have had a family member who was addicted. An indepth knowledge of addiction and the tools for recovery and ability to empathize with the client are essential for an addiction counselor. One way to develop this knowledge and ability is for the counselor to be in recovery. It is important that the counselor be relatively healthy and able to demonstrate a minimum of 5 years in recovery. The best situation is a mixture of recovering and nonaddicted counselors, because this fosters maximum learning from one another.

4.4 Ideal Personal Characteristics of Counselor

Addiction counselors should exhibit good professional judgment, be able to establish rapport with most clients, be good listeners, be accepting of the client for who he or she is (and not have a negative attitude toward working with addicts), and use confrontation in a helpful versus an inappropriate or overly punitive manner. A good addiction counselor must also be personally organized so as to be prompt for all sessions and able to maintain adequate documentation.

4.5 Counselor's Behaviors Prescribed

The counselor will perform the following behavioral tasks:

1. Help the client admit that he or she suffers from the disease of addiction.

2. Teach the client about addiction and about the tools of recovery.

3. Encourage and motivate the client.
4. Monitor abstinence by doing frequent urine drug screens and breathalyzers and by encouraging self-report of any relapse.

5. Analyze any relapse and strongly discourage further use.

6. Introduce or review the 12-step philosophy and encourage regular attendance in a self-help program.

7. Provide support and encourage development of a support network.

4.6 Counselor's Behaviors Proscribed

The counselor should not be harshly judgmental of the client's addictive behaviors. If the client did not suffer from addiction he or she would not need drug counseling, so it is useless to blame the client for exhibiting these symptoms. Also, because clients often feel a great deal of shame and guilt associated with their addictive behaviors, to help resolve those feelings it is important that they be encouraged to speak honestly about drug use and other addictive behaviors and to be accepting of each client's story.

It is also important that the counselor be respectful of clients. The counselor should not be late for appointments and should never treat or talk to clients in a disrespectful manner.

The counselor should avoid too much self-disclosure. While occasional appropriate self-disclosure can help the client to open up or motivate the client by providing a role model, too much self-disclosure removes the focus from the client's recovery. A good rule regarding self-disclosure, if the counselor is so inclined, is that the counselor first have a clear purpose or goal for the intervention and then think about why he or she is choosing self-disclosure at this time.

Finally, the counselor should be aware of when his or her own issues are stimulated by a client's problems and therefore refrain from responding to the client out of his or her own dynamics. For example, if a counselor in recovery feels it extremely important to break ties with addicted peers, but a particular client with an addicted spouse or partner cannot break free of the relationship, it is imperative that the counselor respond flexibly and creatively to the client's perception of the situation and not rigidly adhere to the notion that breaking ties with all addicts is the only way to recovery.

4.7 Recommended Supervision

Ongoing supervision is a necessary part of counselor training and support. Lack of adequate supervision can contribute to counselor stress and burnout, both of which are seen frequently.

The ultimate goal of supervision is to enhance the quality of client care. Focus to achieve this goal is twofold. First, it is centrally important that the supervisor provide support and encouragement to the counselor along with the opportunity to expand his or her skills. Second, it is important that the supervisor have the opportunity to review the clinical status of clients and offer suggestions or corrections.

The format of supervision is for each individual to have a supervisor and meet with that supervisor for 1 hour once a week to review counseling sessions. Individual counseling sessions are audiotaped, and the supervisor is responsible for listening to a percentage and rating them for adherence to the counseling manual. This feedback is then given to the counselor.

5. CLIENT-COUNSELOR RELATIONSHIP

5.1 What Is the Counselor's Role?

The role of the counselor is to provide support and education and to hold the client accountable through nonjudgmental confrontation. Ideally, the recovering person sees the counselor as an ally in the struggle to achieve sobriety.

5.2 Who Talks More?

The client should talk more than the counselor. The counselor should structure the session and provide information and direction, but also do a lot of listening.

5.3 How Directive Is the Counselor?

The counselor must find a balance between being directive and allowing the client to be self-directed. The counselor must be directive in many ways. The counselor imposes a session structure that includes giving feedback on the most recent urine drug screens and the client's progress in recovery as well as processing any episodes of use or near use. The counselor identifies the relevant topic for discussion, based on what the client seems to need, and introduces that topic. Also, the counselor may directly pressure the client to change certain behaviors, for example, to start attending three meetings a week. However, the client is also encouraged to be self-directed in this counseling approach. For example, within the framework of a particular topic, such as coping with social pressure to use, the client will ventilate or explore the direction he or she needs to take, and the counselor will respond to the client's direction. Also, when the client is unable to change an addictive behavior, such as being in a dangerous situation, the appropriate counselor response is to accept where the client is and assist in exploring what the client can do to handle the situation differently the next time.

Ultimately, recovery is seen as the client's responsibility, and the counselor wants to encourage self-directed movements toward the recovery. However, the counselor will discourage movements toward addiction in a number of ways, many of which are directive.

5.4 Therapeutic Alliance

It is important for the counselor to give the client a sense of collaboration and partnership in the counseling relationship. This is accomplished in three ways. First, the counselor should possess a thorough knowledge of addiction and the lifestyles of addicts. Second, no matter how expert the counselor is in the field, he or she must acknowledge that it is the client who is the expert in discussing his or her own life. The counselor must listen well, empathize, and avoid passing judgment. Third, the counselor should convey to the client that he or she has an ally in the struggle to break the cycle of addiction. Their relationship is a collaborative one.

Generally, the interventions that are most helpful in fostering a strong therapeutic alliance (TA) are those that involve the counselor's active listening and that emphasize collaboration. For example, after the client reports a relapse, the counselor might say empathically, "Let's examine what happened and develop a plan together to help you avoid using the next time." Language like this highlights the joint effort in the relationship.

If the TA initially seems weak, the counselor might find it helpful just to ask the client what is not working in the relationship. Often the client knows what might improve the therapeutic relationship but does not feel comfortable enough to mention it unless the counselor does so. It is important that the counselor be willing to accept feedback from the client and make changes if necessary. In responding to a request to change, the counselor should not feel pressured to change or compromise his or her philosophy of addiction but only the manner of relating to the client.

6. TARGET POPULATIONS

6.1 Clients Best Suited for This Counseling Approach

This treatment has been developed for adult male and female ambulatory cocaine addicts. It has also been used with individuals addicted to alcohol and with those addicted to cocaine and other drugs, including alcohol, marijuana, and opiates, who have found it to be appropriate.

6.2 Clients Poorly Suited for This Counseling Approach

Dually diagnosed individuals with significant psychopathology probably require more attention to the psychopathology than this approach provides. Previous research has shown that addicts with more psychopathology derive greater benefit from psychotherapy combined with addiction counseling than from addiction counseling alone.

Other research has indicated that most antisocial individuals do not fare particularly well with any type of psychosocial treatment.

7. ASSESSMENT

The only assessment procedures that are necessarily a part of the addiction counseling treatment are the frequent, regular urinalysis and breathalyzer tests and self-reports of any drug use. The other assessment instrument routinely used in association with treatment is the Addiction Severity Index (ASI), an interview schedule that measures seven addiction-related domains: drug use, alcohol use, medical problems, psychiatric problems, legal problems, family/social problems, and employment/support problems. Because this interview examines problems and drug use over the previous month, it should be given at baseline, when the client enters treatment, and then either monthly or after 3 or 6 months to measure change. It requires approximately 45 minutes for the initial administration and about 30 minutes for a followup administration.

8. SESSION FORMAT AND CONTENT

8.1 Format for a Typical Session

In each individual session the counselor should:

- Find out how the client has been since the last session and ask specifically if the client has used any drugs. If the client has used drugs, analyze the relapse and develop strategies to prevent future relapses.
- Ask if there are any urgent problems and, if there are, deal with them.
- Provide feedback as to whether recent urine tests have detected drug use.
- Discuss the recovery topic most relevant to the client's stage of recovery and current treatment needs.

Group sessions have the following format:

- Members submit a urine sample and take a breathalyzer test.
- Members introduce themselves, admit to their addiction, and state their date of last use of any type of drug or alcohol.
- Members are encouraged to talk briefly about how they are doing and about any cravings or temptations experienced since the previous group meeting.
- If any members have used since the last session, the group will help them process the event and develop a plan to prevent further relapse.
- If there is a topic, the group leader will introduce it and encourage members to discuss how it relates to their recovery. (In the more advanced problemsolving group, members are encouraged to describe a current problem or concern and get feedback from one another.)

- In the final 10 minutes, members are asked to state their plans for the next few days in an effort to help them structure their time. Members are also encouraged to mention the self-help meetings that they are attending and perhaps invite others to attend with them.
- Members then join hands and recite the Serenity Prayer aloud.

8.2 Several Typical Session Topics or Themes

Treatment is conceptualized as occurring in stages. The first stage includes denial and motivation.

The next stage, early abstinence, includes issues of:

1. Addiction and associated symptoms.
2. People, places, and things.
3. Structure of personal time.
4. Craving.
5. High-risk situations.
6. Social pressures to use.
7. Compulsive sexual behavior.
8. Postacute withdrawal symptoms.
9. Use of other drugs (other than the primary addiction).
10. Self-help participation.

The next stage, maintaining abstinence, includes:

1. The relapse process and tools for preventing it.
2. Relationships in recovery.
3. Development of a drug-free lifestyle.
4. Spirituality.
5. Shame and guilt.
6. Personal inventory.
7. Character defects.
8. Identification and fulfillment of needs.
9. Anger management.
10. Relaxation and leisure time.
11. Employment and finances.
12. Transference of addictive behaviors.

8.3 Session Structure

Both group and individual sessions have a clear structure. However, within the framework of that structure, the content of the discussion is largely up to the client. An effort is made to address effectively the client's individual needs at any point in treatment while also recognizing the commonality of many issues in addiction and recovery.

8.4 Strategies for Dealing With Common Clinical Problems

Clients are repeatedly urged to arrive for all sessions promptly, to call if they are going to be late, and to call at least 24 hours in advance if they must cancel a session. If they fail to fulfill these obligations, the counselor will confront them about it in the session.

If a client arrives late for a session, the consequence is a shorter session because the counselor will end the session on time. Repeated missed sessions without appropriate cancellations and rescheduling will eventually result in dismissal from the program, but because this occurs only after 2 months, clients are given many chances before termination from treatment for nonattendance.

Clients are requested to arrive clean for all visits. If a client arrives obviously intoxicated, the counselor will remind the individual of the responsibility to come clean and will reschedule the session. If a client arrives for a group or individual session mildly under the influence but not intoxicated (e.g., blows a low positive on a breathalyzer test), it is at the counselor's discretion whether to continue with or reschedule the session.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

Denial and motivation are central themes in the beginning of addiction treatment. For this reason, they are addressed in the first several sessions of counseling and then repeatedly addressed, as needed, throughout the course of treatment. The major strategy is to chip away at the client's denial by pointing out the addictive behaviors and consequences of addiction and gently confronting the client about the denial.

Resistance is a concept that is not directly addressed in this addiction counseling model. Much resistance falls within the concept of denial and is addressed in that way. Also the 12-step suggestion of turning one's will over to a higher power is a way of dealing with resistance that would be used in this model of counseling.

Regarding motivation, clients often express ambivalence at some point in treatment, and several strategies are used to address this directly. Clients may be encouraged to review the pros and cons of getting sober, or they may be pressed to explore fully the consequences of their addiction. Clients may also be asked to identify specifically the benefits of sobriety in their life. Basically, these issues are reviewed continuously throughout the early period in treatment.

8.6 Strategies for Dealing With Crises

If the client presents with an urgent, addiction-related problem such as marital dissolution or financial problems as a result of the addiction, the counselor should try to address these problems, with emphasis on how they are related to the addictive behavior. The counselor should then help the client develop strategies for dealing with the problems in a manner consistent with recovery, including identifying how to obtain appropriate assistance from social services.

If the client presents with a true crisis (spending all of his or her money on a cocaine binge and becoming suicidal), the counselor should organize a team effort among the appropriate treatment staff to provide any medical or psychiatric services that the client requires in order to remain safe.

8.7 Counselor's Response to Slips and Relapses

If a relapse occurs, the counselor and client should use the session immediately following the relapse to identify and process the events, thoughts, and feelings that precipitated the relapse.

Relapse to drug use is a common occurrence that can be devastating to the client. The counselor must communicate to the client that relapse to drug use does not mean that the entire treatment program has been a failure. The counselor should educate the client about relapse and about how important it is to take corrective action rather than be overcome by feelings of depression or failure. Most episodes of drug use can be managed without seriously interrupting the treatment program and can be used in a positive and educative way to strengthen the recovery process. In dealing with a relapse, the counselor should use the general principle that relapse is caused by failure to follow one's recovery program. Thus, the counselor should identify where the client deviated from his or her recovery plan and help the individual do all that is reasonable to prevent such a deviation from recurring.

Relapse can be viewed as having differing levels of severity that determine the appropriate therapeutic response. The counselor must understand the appropriate interventions to be used in each case.

The least severe type of relapse is a slip. A slip is a common occurrence involving a very brief episode of drug use that is associated with no signs or symptoms of the addiction syndrome, as defined in DSM-III-R criteria. Such an episode can serve to strengthen the client's recovery if it is used to identify areas of weakness and point out solutions and alternative behaviors that can help prevent future drug use from occurring.

The next most severe type of relapse is when the client resumes drug use for several days, and the use is associated with some of the signs and symptoms of addiction. In such a case, the counselor might want to intensify treatment temporarily. This intensified contact will usually reinstitute abstinence. The client should be encouraged to think about what was done and learn from the experience how to avoid relapse in the future. The client should also be encouraged to recommit to his or her recovery program.

The most serious form of relapse is a sustained period of drug use during which the client fully relapses to addiction. Often a client who relapses to this extent will also drop out of treatment, at least temporarily. In this case, if the client returns to treatment, he or she should most likely be detoxified again, either in an inpatient or outpatient setting. The decision to detoxify a client as an inpatient or an outpatient should be made conjointly by the treatment staff involved. The decision should be based on the severity of the relapse, availability of social support, and presence of unstable medical or psychiatric conditions.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

This model of addiction counseling does not focus much attention on the role of family members in treatment, not because it is not important in treatment but because this model is not intended to provide all-inclusive treatment. This model offers the individual and the group the addiction counseling components of a treatment program that can include numerous other components.

In general, the inclusion of partners, family members, and even close friends in addiction treatment by holding family sessions can facilitate recovery. Encouraging family involvement can help the addict create a better, more knowledgeable support network; it may decrease the family's enabling or codependent behaviors that tend to impede the addict's recovery; and it will allow the counselor to intervene in any upsetting family situations that might otherwise potentiate a relapse.

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Description of the Solution-Focused Brief Therapy Approach to Problem Drinking

Scott D. Miller

1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

The Solution-Focused Model is a brief therapy approach developed over the past 20 years at the Brief Family Therapy Center in Milwaukee, WI. The model continues to evolve and be applied to a variety of presenting problems and across a number of treatment settings. Research now continues at Problems to Solutions, Inc., a clinic that provides free services to the traditionally underserved population, specializing in the treatment of homeless, drug-abusing males. Primarily, the model is designed to help clients engage their own unique resources and strengths in solving the problems that bring them into treatment.

1.2 Goals and Objectives of Approach

Goals are the entire focus of the solution-focused brief therapy approach. The model uses a specialized interviewing procedure to negotiate treatment goals whose qualities facilitate efficient and effective treatment. The goals must be:

- Salient to the client rather than the therapist or treatment program.
- Small rather than large.
- Described in specific, concrete, and behavioral terms.
- Described in situational and contextual rather than global and psychological terms.
- Stated in interactional and interpersonal rather than individual and intrapsychic terms.
- Described as the start of something rather than the end of something.
- Described as the presence of something rather than the absence of something.
- Realistic and immediately achievable within the context of the client's life.

After a goal is negotiated, the model specifies how to use a client's own unique resources and strengths to accomplish the goal. Two such resources and strengths are known as exceptions and instances. Exceptions are periods of time when the client does not experience the problem or complaint for which he or she is seeking treatment. Instances, however, are periods of time when the client experiences his or her problems either in whole or in part. Interviewing methods are used to elicit information about the occurrence of exception and instance periods so that they may be repeated in the future.

1.3 Theoretical Rationale/Mechanism of Action

The approach proposes that the solution(s) to the problems that a client brings into treatment may have little or nothing to do with those problems. This is particularly true in the treatment of problem drinking, where any of a variety of life experiences or actions on the client's part, which have little to do with his or her use of alcohol, may result in a resolution of the problem. While the number of potential solutions is limitless, one example is a problem drinker who stops using problematically when he or she:

- Obtains employment.
- Ends or begins a relationship.
- Makes new friends.
- Relocates.

Treatment therefore need not make alcohol the primary focus to resolve the drinking problem. Rather, the focus returns to helping the client achieve the personal goals he or she sets.

1.4 Agent of Change

In the Solution-Focused Model, there is no one agent of change primarily responsible for positive treatment outcome. Indeed, in the solution-focused approach, the question as to the agent of change may be viewed as one that obscures rather than clarifies the nature of most successful treatment contacts. The solution-focused counselor assumes that change is constant and inevitable and would suggest that the successful counselor need only tap into and utilize that existing change rather than create or cause change.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

Problems with alcohol and other drugs are seen as multidetermined, resulting most likely from a combination of factors both environmental and biological. There is no one alcoholism but many different alcoholisms. The sheer diversity of causative factors and problems resulting from alcohol and other drugs suggests that:

- No one treatment methodology can help all people.
- A diverse package of treatment strategies is needed.
- Treatment strategies should be developed and matched to meet the needs of the individual client.

2. CONTRAST TO OTHER COUNSELING APPROACHES

2.1 Most Similar Counseling Approaches

Some of the motivational enhancement therapy interviewing components by Hester and Miller (1989) are similar to this model (also see the chapter in this volume by William R. Miller), as are some interviewing procedures of the cognitive and cognitive-behavioral treatment programs.

2.2 Most Dissimilar Counseling Approaches

Although the various procedures of the Solution-Focused Model can be incorporated into most existing treatment approaches, the model is likely to be most different in terms of assumptions from the more traditional treatment approaches (e.g., 12-step, recovery-oriented approaches).

3. FORMAT

3.1 Modalities of Treatment

The solution-focused model was developed as a family therapy approach, but it is now being used in a variety of formats including individual, couple, family, and group. In each of these formats, the approach remains largely the same. The only major difference is that specialized interviewing techniques have been developed to encourage and incorporate the participation of multiple participants when the model is applied in couple, family, and group formats.

3.2 Ideal Treatment Setting

The solution-focused approach was first used in a private, nonprofit, outpatient treatment agency. It has since evolved into use in inpatient and residential settings. There seems to be no ideal setting for the model. However, it is unclear why the model would be applied in these latter settings as the expense is so much higher and the results, compared with outpatient settings, are largely similar.

3.3 Duration of Treatment

Being a "brief" treatment model, the average number of counselor-client contacts is 4.7, with a range of between 1 and 12 sessions. Typically, these treatment contacts occur in a 3- to 4-month period. The treatment is open ended, however, with clients being made aware that they may return in the future for any reason.

3.4 Compatibility With Other Treatments

As indicated earlier, solution-focused techniques can be incorporated with most other treatment models. The idea is to help each client maximize his or her success by utilizing his or her unique resources and strengths within whatever treatment model is applied. One example of adapting the model to fit within traditional treatment settings can be found in the work of Campbell and Brashera (1994).

3.5 Role of Self-Help Programs

The Solution-Focused Model neither encourages nor discourages clients from attending existing self-help programs.

4. COUNSELOR CHARACTERISTICS AND TRAINING

4.1 Educational Requirements

As the model has been taught to largely professional audiences, the majority of people trained in this method have some type of graduate degree or professional certification (e.g., psychologists, social workers, alcohol and other drug counselors, certified employee assistance program coordinators). However, the model does not require a special educational background in the social sciences. Indeed, in one project with homeless clients, formerly homeless males who had alcohol and other drug problems have been taught the model and work as peer counselors. A number of these men now sit on the board of Problems to Solutions, Inc.

4.2 Training, Credentials, and Experience Required

People can receive training by participating in several different programs at Problems to Solutions, Inc., or they may receive training from other specialized centers. These week-long or month-long programs are divided into beginning, intermediate, and advanced levels. A certificate indicating completion of the program is offered at the end of the training. However, given that no certification process exists at this time, certificates from existing training programs do not guarantee proficiency in the model but only completion of the training program. Supervision is offered and encouraged.

4.3 Counselor's Recovery Status

The status of the counselor's former use/problems with alcohol or other drugs is seen as nonessential to practicing the solution-focused brief treatment model.

4.4 Ideal Personal Characteristics of Counselor

Certainly, the characteristics of a successful counselor would be seen as adding to the efficacy of solution-focused brief treatment. However, personal characteristics of the counselor are not viewed as central to the treatment process. If one characteristic does stand out, it would probably be flexibility.

4.5 Counselor's Behaviors Prescribed

The majority of the solution-focused process consists of carefully crafted questions designed to elicit client strengths and resources and to help the client decide how to best use those strengths and resources to achieve the desired treatment objectives.

4.6 Counselor's Behaviors Proscribed

It is difficult to say which if any specific behaviors on the part of the counselor are generally proscribed. Rather, there are certain behaviors that are used very infrequently by solution-focused counselors. These are, for example, advice giving, education about the effects of alcohol or other drugs, confrontation, indoctrination into a specific model or view of alcohol/other drug problems, labeling with psychiatric or other diagnoses (e.g., codependent), focusing on abstinence, and so forth.

4.7 Recommended Supervision

No formal network of solution-focused counselors exists for obtaining supervision in the method. At present, the majority of supervision is done on a one-to-one basis over the telephone with a recognized leader in the field. People being trained in the model are encouraged to seek supervision, however, since the approach appears easier to practice than is actually the case. Goals for supervision are determined in much the same way that goals are determined for therapy; that is, they are determined by the interests and concerns of the professional receiving the supervision.

5. CLIENT-COUNSELOR RELATIONSHIP

5.1 What Is the Counselor's Role?

In the solution-focused approach, the counselor is seen as a collaborator/consultant hired by the client to achieve the client's goals. This differs from the more traditional approach in two primary ways. First, in traditional treatment the counselor is viewed as the expert. Second, the goals and objectives of traditional treatment are frequently determined by the counselor or treatment model to which he or she adheres.

5.2 Who Talks More?

In the majority of cases, the client does the most talking. Furthermore, because of the collaborative nature of the relationship, what the client says is considered essential to the resolution of his or her complaints.

5.3 How Directive Is the Counselor?

In the majority of client-counselor contacts, the model is indirectly influencing the client through the use of specialized questions. However, the counselor would be more likely to be directive in the Solution-Focused Model if previous directive therapies had been helpful to the client or the client's frame of reference about the helping relationship.

5.4 Therapeutic Alliance

The Solution-Focused Model was developed largely on a population that was mandated into treatment. To promote positive working relationships with this clientele, a classification system was developed to match interviewing techniques to the individual client's level of motivation or willingness to work.

6. TARGET POPULATIONS

The approach was developed for low-income clients with serious alcohol or other drug problems. Many were African-American. The majority of clients served by Problems to Solutions, Inc., are unemployed and may be homeless at the time treatment is initiated. As the model has evolved, however, it has been applied across a variety of settings and treatment populations. The approach has also been used with clients who use a variety of drugs. Because the model stresses that the problem and solution are not necessarily related, the type of drug is not seen as a critical factor in determining differential treatment.

6.1 Clients Best Suited for This Counseling Approach

Available research suggests that the approach may be helpful across a broad range of drug-abusing clients.

6.2 Clients Poorly Suited for This Counseling Approach

Provisions are made in the model for dealing with difficult cases; in other words, those cases for which the model does not seem to work.

7. ASSESSMENT

Standard forms for insurance and State certification requirements are completed by the client. These forms contain a list of complaints, client history in treatment, client history of alcohol and other drug problems, and so forth. In solution-focused therapy, no formal assessment is completed aside from the specialized interviewing questions that are the hallmark of the model. After completion of the State certifications and insurance forms, the treatment process begins. This is because all questions are considered interventions. It is, therefore, not possible to do an assessment without impacting the client.

Outcome is assessed via scaling questions during the treatment process and after treatment in followup interviews conducted at 6, 12, and 18 months.

8. SESSION FORMAT AND CONTENT

8.1 Format for a Typical Session

First sessions are considered the most important interview in the treatment process. These generally begin with questions that are designed to negotiate treatment goals and orient the client toward the strengths and resources that will be used to accomplish those goals. This is followed by a team break, when the counselor meets with fellow professionals who have observed the session from behind a one-way mirror. Team members are usually made up of trainees and staff at the treatment center. Together, the team and the counselor construct a summary message and homework task that match the goals and motivational level of the client. There are three general types of homework tasks.

1. Those that help the client change actions.
2. Those that help the client change personal views or thinking.
3. Those that encourage the client to return for subsequent sessions.

Second and subsequent interviews use interview questions to elicit, amplify, and reinforce the changes the client is making or to renegotiate goals if progress is not forthcoming. These sessions also utilize the team break and message components of the first session. Cases may or may not be seen with a team during subsequent sessions depending on the availability of other team members and the status of the case.

8.2 Several Typical Session Topics or Themes

Typical themes in solution-focused therapy include:

- The outcome that the client desires from the treatment process.
- Strengths and resources of the client that can be used to achieve the desired outcome.
- Discussion of previous successes of the client.
- Discussion of exception and instance periods.
- Discussion of changes in the client's life from session to session.
- Exploration of what the client does to achieve those changes.

Session themes are believed to result from the interaction between the client and the counselor.

8.3 Session Structure

The session content is largely structured by the client. However, as noted in section 8.2, there is a loose structure inherent in the model and in the series of interviewing techniques that guide the individual interview.

8.4 Strategies for Dealing With Common Clinical Problems

All client behaviors are interpreted as efforts to aid the counselor in learning the best way to help each individual client. Therefore, the counselor must decide how to best incorporate and utilize whatever behavior is exhibited by the client. This attitude fosters a cooperation between the counselor and client that is not likely to occur when client behaviors are viewed as problems that must be dealt with to ensure the integrity of the treatment process. A common-sense attitude prevails. For example, if a client is chronically late to a session, this would be interpreted as a message to the counselor that too many appointments are being scheduled. After communicating this to the client, a suggestion might be made that the client call on the day that he or she would like an appointment. If an appointment is available, then the client would be seen. If, however, no appointment were available, the client would be instructed to call on another day. The same attitude prevails with regard to other common clinical problems.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

In the Solution-Focused Model, all of these terms are seen as evidence of the counselor's difficulty (failure) in cooperating with the client's frame of reference or level of motivation. For example, the word "poor" in reference to the client's level of motivation is an indication that the counselor has made a judgment that the client is not at the level that the counselor would like. Therefore, in this model, there are no poorly motivated clients, only counselors who poorly match their client's frame of reference or level of motivation.

8.6 Strategies for Dealing With Crises

A variety of specialized interviewing techniques are utilized in the Solution-Focused Model that help the client quickly reorient to strengths and resources when experiencing a crisis. One example of these interviewing techniques is known as the coping sequence. When a client calls in a crisis, questions are used that focus attention on how the client is or how to cope with the situation rather than on what is causing the crisis or how bad the client feels.

8.7 Counselor's Response to Slips and Relapses

As change is inevitable and constant, there can technically be no relapses back to a previous level but only to different, new experiences. Therefore, in the Solution-Focused Model, such occurrences are considered new experiences and challenges and even signs of success. After all, a client cannot have a slip or relapse without first having been successful. In these instances, the choice of the solution-focused counselor is to focus on exactly what the client was doing when he or she was feeling more successful and to encourage the client to begin doing more of that again. This is a perfect example of the resource, competency-based perspective of the model.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

The Solution-Focused Model, as indicated earlier, began as a family therapy approach. Over time, it has been discovered that the model can affect family systems—and the individuals within that system—when only a few members of the system come to treatment. Sometimes this means that the identified client may not even come to the treatment sessions but will still be helped by the process. Therefore, when any potential client calls for an appointment, he or she is told to bring anyone that might be useful in solving this problem. If a certain member—even the identified client—is not willing to come to treatment, the willing members are instructed to come.

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Motivational Enhancement Therapy: Description of Counseling Approach

William R. Miller

1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

Motivational Enhancement Therapy (MET) seeks to evoke from clients their own motivation for change and to consolidate a personal decision and plan for change. The approach is largely client centered, although planned and directed.

1.2 Goals and Objectives of Approach

As applied to drug abuse, MET seeks to alter the harmful use of drugs. Because each client sets his or her own goals, no absolute goal is imposed through MET, although counselors may advise specific goals such as complete abstention. A broader range of life goals may be explored as well.

1.3 Theoretical Rationale/Mechanism of Action

MET is based on principles of cognitive and social psychology. The counselor seeks to develop a discrepancy in the client's perceptions between current behavior and significant personal goals. Consistent with Bem's self-perception theory, emphasis is placed on eliciting from clients self-motivational statements of desire for and commitment to change. The working assumption is that intrinsic motivation is a necessary and often sufficient factor in instigating change.

1.4 Agent of Change

The client is the agent of change, with assistance from the counselor.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

Drug problems are viewed as behaviors under at least partial voluntary control of the client, which are subject to normal principles of behavior change. Drugs of abuse are assumed to offer inherent motivating properties to the drug abuser, which by definition have overridden competing motivations. The task in MET is to elicit and strengthen competing motivations.

2. CONTRAST TO OTHER COUNSELING APPROACHES

2.1 Most Similar Counseling Approaches

MET bears many similarities to Rogerian client-centered counseling but is directive rather than nondirective. There are also certain similarities to cognitive therapy and reality therapy.

2.2 Most Dissimilar Counseling Approaches

MET is strikingly dissimilar from counseling approaches designed to oppose denial and break down defenses through direct confrontation. Furthermore, MET differs from behavioral approaches in that no direct advice or skill training is provided.

3. FORMAT

3.1 Modalities of Treatment

MET is typically conducted as individual counseling, though family members may also be present and engaged. Group MET is conceivable but untested.

3.2 Ideal Treatment Setting

MET has been tested and found effective in both outpatient and inpatient settings. There is no necessary or ideal setting.

3.3 Duration of Treatment

MET is typically brief, limited to two to four sessions that each last 1 hour.

3.4 Compatibility With Other Treatments

MET can be a suitable prelude to other treatment approaches designed to enhance treatment response. It has been shown to increase client compliance in subsequent alcoholism treatment and thereby to improve outcome.

3.5 Role of Self-Help Programs

MET does not formally involve any self-help group, although participation in such groups may be part of a client's chosen change plan. MET is wholly compatible with a 12-step approach.

4. COUNSELOR CHARACTERISTICS AND TRAINING

4.1 Educational Requirements

MET has been effectively administered by prebachelor's-level university students working as supervised paraprofessional counselors. Education level may not be a critical determinant of effectiveness in using MET.

4.2 Training, Credentials, and Experience Required

Specific training in MET is important. A skillful MET practitioner makes the process look easy and natural, but in fact the component skills require substantial practice and shaping.

Initial intensive training of 2 to 3 days with subsequent supervised experience in MET is recommended. Training initially focuses on the rationale for MET and the establishment of sound reflective listening skills without which other aspects of MET cannot be implemented effectively. Once these skills are in place, training proceeds to other strategies for enhancing motivation and strengthening commitment to change. Counselors new to this approach are unlikely to implement it successfully, based on a single workshop, without ongoing supervision.

4.3 Counselor's Recovery Status

The counselor's recovery status is largely irrelevant in MET. Some research has found that counselors in early recovery tend to overidentify with clients and have difficulty in separating their own issues and advice from the counseling process. This would be a particular hindrance in MET.

4.4 Ideal Personal Characteristics of Counselor

MET requires a high level of therapeutic empathy as defined by Carl Rogers (as opposed to empathy in the sense of having had similar experiences). High interpersonal warmth and congruence are also desirable. Counselors who cannot suspend their own needs, perceptions, and advice are ill suited to MET.

4.5 Counselor's Behaviors Prescribed

Common counselor behaviors in MET include asking open-ended questions, reflective listening, reframing, and supporting. A key strategy is developing discrepancy by eliciting the client's own verbal expression of problems, concerns, reasons for change, and optimism regarding change. Counselors are instructed to "roll with" resistance rather than confronting it directly. Emphasis is also given to supporting client self-efficacy, the perception that change is possible and can be accomplished by the client. Assessment findings are often used as personal feedback to instill client motivation.

4.6 Counselor's Behaviors Proscribed

Most important is for the counselor to avoid what is termed the confrontation/denial trap, in which the counselor is placed in the position of defending the presence of a problem and the need for change, while the client argues that there is no problem or need for change. Argumentation is generally proscribed. The counselor also avoids taking on an "expert" role, which implies that the counselor will impart the solution to the client. Relatedly, counselors are encouraged to avoid "closed" (short answer) questions and specifically to avoid asking three questions in a row. Diagnostic labeling as problem drinker or alcoholic, for example, is specifically avoided.

4.7 Recommended Supervision

Direct observation of sessions is vital to effective supervision with MET. Counselors are least able to observe or convey the very behaviors they most need to change. In advance of or during supervision, supervisors should review videotape or audiotape of sessions. It is particularly helpful for the supervisor and those supervised to use a structured observation sheet in following the sessions, coding the content of counselor and client responses as a means of attending to process rather than being caught up in content. Specific workshops for trainers of motivational interviewing are offered periodically.

5. CLIENT-COUNSELOR RELATIONSHIP

5.1 What Is the Counselor's Role?

The counselor's primary role is to elicit and consolidate the client's intrinsic motivations for change. This facilitator role may include minor aspects as educator and collaborator. The expert/adviser role is deemphasized. When personal assessment feedback is provided as part of MET, the counselor temporarily assumes the role of educator.

5.2 Who Talks More?

The client should do more than half of the talking, except during a period of personal assessment feedback when the counselor has a substantial explanatory role.

5.3 How Directive Is the Counselor?

MET sessions are client centered but directive. There is a specific objective that the counselor pursues through systematic strategies. When MET is successfully conducted, however, the client does not feel directed, coerced, or advised. Direction is typically accomplished through open-ended questions and selective reflection of client material rather than through more overtly confrontational strategies and advice giving. To use a metaphor, the client and counselor are working a jigsaw puzzle together. Rather than putting the pieces in place while the client watches, the counselor helps to construct the frame, then puts pieces on the table for the client to place.

5.4 Therapeutic Alliance

The rapid establishment of a working therapeutic alliance is an important aspect of MET. The basic conditions of client-centered therapy provide a strong foundation, with particular emphasis on the strategies of open-ended questions and reflective listening. Such supportive and motivation-building strategies are employed until resistance abates and the client shows indication of being ready to discuss change.

6. TARGET POPULATIONS

6.1 Clients Best Suited for This Counseling Approach

Research to date has found MET to be effective with a broad range of severity of alcohol problems. No unique markers of differential response have been identified. Court-mandated clients appear to respond as favorably as those who are self-referred. One study has shown MET to be differentially effective (relative to a behavioral approach) with clients in the earliest stages of change (i.e., most unmotivated). MET has been evaluated well with problem drinkers, but its results are less studied with other drug problems. Two studies have reported positive results with marijuana and heroin users. The basic therapeutic style would remain the same regardless of target drug, but specific content (e.g., assessment feedback) may vary.

6.2 Clients Poorly Suited for This Counseling Approach

MET may be insufficiently directive for clients who desire clear direction and advice.

Research to date has identified no client characteristics that predict poorer response to MET than to alternative approaches. Brief counseling in general may be less effective as a stand-alone treatment with more severely impaired clients.

7. ASSESSMENT

MET commonly includes a structured assessment of use, consequences, addiction, biomedical sequelae, family history, and other risk factors. A variety of specific instruments could be used to assess these dimensions. Instruments that are sensitive to early stages of impairment are particularly desirable. A common sequence is to conduct a brief motivational interview to prepare the client for assessment. This is followed by structured assessment including the above dimensions. A third session then provides the client with personal feedback regarding the findings from assessment in relation to norms.

8. SESSION FORMAT AND CONTENT

8.1 Format for a Typical Session

The content of an MET session depends on the client's stage of motivation. Prochaska and colleagues (1992) have described four stages of readiness:

1. Precontemplation, in which the individual is not considering change.

2. Contemplation, in which the individual is ambivalent, weighing the pros and cons of change.

3. Determination or preparation, where the balance tips in favor of change and the individual begins considering options.

4. Action, which involves the individual taking specific steps to accomplish change.

With precontemplators, the counselor explores perceived positive and negative aspects of use. Open-ended questions are used to elicit client expression, and reflective paraphrase is used to reinforce key points of motivation. During a session following structured assessment, most of the time is devoted to explaining feedback to the client. Later in MET, attention is devoted to developing and consolidating a change plan.

8.2 Several Typical Session Topics or Themes

The theme of the session is typically determined by the counselor, but specific content within the theme is provided by the client. Examples of common themes include:

- Good and not-so-good things about use.
- A typical day involving use.
- Reasons to quit or change.
- Ideas about how change might occur.

Sessions commonly begin with open-ended questions and end with a summary reflection.

8.3 Session Structure

Sessions are rather structured, although in presentation they are flexible and client centered.

8.4 Strategies for Dealing With Common Clinical Problems

Resistance of all types is met by a reflective "rolling with" strategy, rather than direct confrontation or opposition. For example, client minimization or rationalization might be met with various forms of reflective listening, such as double-sided reflection, where both sides of ambivalence are captured. The counselor might also agree with the client's point but then reframe it. Standard program rules (e.g., regarding coming to sessions under the influence) may, of course, still be enforced.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

The central characteristic of MET is as follows: Resistance and poor motivation are not regarded as client characteristics but rather as cognitions and behaviors subject to interpersonal influence. Research demonstrates that a counselor can drive resistance levels up and down dramatically according to his or her personal counseling style. A respectful, reflective approach is used throughout MET with minimal advice or direction. The goal is still confrontation in the sense of bringing the client face to face with a difficult reality and thereby initiating change. Common strategies for decreasing resistance behaviors include variations on reflective listening (e.g., amplified reflection, in which the counselor takes the client's resistance a step further), reframing or giving a new meaning to what the client has said, and selective agreement. Many of these take the form of the counselor giving voice to the client's resistance, seeking to elicit the client's own verbalizations of the need for change.

8.6 Strategies for Dealing With Crises

Crises often offer particularly good windows of opportunity for motivation. Rapid availability of the MET counselor is desirable. Beyond the taking of immediate actions necessary to ensure safety, counseling strategies remain largely the same.

8.7 Counselor's Response to Slips and Relapses

Occurrences of renewed use are queried through open-ended questions and are explored through reflective listening. Judgmental responses are carefully avoided. The client's own perceptions of the slip or relapse are explored, and renewed attention is given to the change plan and to what if anything may have been faulty in the prior plan.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

Significant others (SOs) may be involved in MET sessions and can be useful sources of motivational material and change plans. The counselor must ensure that the SO does not behave in a manner that elicits resistance and inhibits motivation for change. The SO's primary role is to offer his or her own observations and perceptions, with focus remaining on eliciting the client's intrinsic motivation. The counselor may also employ MET strategies to strengthen the SO's own motivation for change and elicit plans for behavior change. SO involvement can also make reasons for change more salient for the client. The implicit goal remains to instigate change in the client.

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Twelve-Step Facilitation

Joseph Nowinski

1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

Twelve-Step Facilitation (TSF) consists of a brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse/alcoholism and other drug abuse/addiction. It is intended to be implemented on an individual basis in 12 to 15 sessions and is based in behavioral, spiritual, and cognitive principles that form the core of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). It is suitable for problem drinkers and other drug users and for those who are alcohol or other drug dependent.

1.2 Goals and Objectives of Approach

TSF seeks to facilitate two general goals in individuals with alcohol or other drug problems: acceptance (of the need for abstinence from alcohol or other drug use) and surrender, or the willingness to participate actively in 12-step fellowships as a means of sustaining sobriety. These goals are in turn broken down into a series of cognitive, emotional, relationship, behavioral, social, and spiritual objectives.

1.3 Theoretical Rationale/Mechanism of Action

The theoretical rationale is based in the 12 steps and 12 traditions of AA and includes the need to accept that willpower alone is not sufficient to achieve sustained sobriety, that self-centeredness must be replaced by surrender to the group conscience, and that long-term recovery consists of a process of spiritual renewal. The primary mechanism action is active participation and a willingness to accept a higher power as the locus of change in one's life.

1.4 Agent of Change

The facilitator in the TSF treatment model is more truly a facilitator of change than an agent of change. The true agent of change (i.e., sustained sobriety) lies in active participation in 12-step fellowships like AA and NA along with the principles set forth in the 12 steps and 12 traditions that guide these fellowships.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

Alcoholism and other drug addiction are considered illnesses that affect individuals both mentally and physically in such a way that they are unable to control their use of alcohol or other drugs. Viewed from this perspective, the concept of controlled use of alcohol or other drugs amounts to denial of the primary problem, that is, loss of control. Specific causative factors are of less relevance in recovery than is acceptance of both the loss of control and the need for abstinence and a willingness to follow the pathway laid out in the 12 steps.

2. CONTRAST TO OTHER COUNSELING APPROACHES

2.1 Most Similar Counseling Approaches

TSF has its roots in the Minnesota Model first described by Daniel J. Anderson and as implemented in most AA-oriented treatment programs (e.g., the Hazelden Foundation, the Betty Ford Foundation, the Sierra Tucson Center, and others). These models assume addiction can be arrested but not cured, ascribe to the AA/NA philosophy as described in AA/NA literature that relies heavily on a combination of spirituality and pragmatism, and advocate peer support as the primary means for achieving sustained sobriety.

2.2 Most Dissimilar Counseling Approaches

Any approach that advocates controlled use of alcohol or other drugs (as compared with abstinence) is fundamentally dissimilar to TSF with respect to basic treatment goals. Cognitive-behavioral approaches that are based on the idea that problem drinking and other drug use stem primarily from inadequate stress management skills and that aim to enhance problemsolving and coping skills differ from TSF with respect to the assumption of peer support as fundamental to recovery. TSF also assumes that alcoholism and other drug addiction are primary diagnoses and not symptoms of another diagnosis (e.g., depression, antisocial personality).

3. FORMAT

3.1 Modalities of Treatment

TSF was designed to be used in the context of short-term individual counseling but has been adapted for use in a group format. One part of TSF (the conjoint program) is specifically intended to be implemented through sessions with a significant other (SO).

3.2 Ideal Treatment Setting

To date, TSF has been implemented exclusively in the context of outpatient treatment, although it has been used with both individuals who have never sought treatment before (true outpatients) and those who had previous inpatient treatment (aftercare clients). The model is flexible enough, consisting of both core and elective programs, to accommodate both of these client groups. However, since TSF relies heavily on client involvement in community-based 12-step meetings, it would be less ideally implemented in an inpatient setting. TSF can easily be integrated into a general mental health outpatient clinic setting.

3.3 Duration of Treatment

TSF is manual guided and time limited. It is intended to be implemented in 12 to 15 sessions spread over approximately 12 weeks. For nonalcohol drug addiction, it is recommended that clients be seen twice a week for the first 3 weeks. The initial assessment session runs 1½ hours, and regular sessions are intended to last 1 hour.

3.4 Compatibility With Other Treatments

TSF may be utilized in combination with supportive pharmacotherapy for both alcoholism and other drug addiction. While recognizing the existence of multiple problems of adjustment in most problem drinkers and other drug users (e.g., marital conflict, family dysfunction), TSF advocates pursuing the goal of early recovery as primary, delaying most other therapies if necessary, until the client has achieved approximately 6 months of sobriety. The primary exceptions to this recommendation would be debilitating depression or other major affective disorder, or a psychotic disorder, which would take precedence over TSF. TSF is not compatible with treatments based on notions of controlled use.

3.5 Role of Self-Help Programs

Participation in self-help groups is central to TSF and is regarded as the primary agent of change. Specific objectives within TSF include attending 90 AA or NA meetings in 90 days, getting and using members' phone numbers, getting a sponsor, and assuming responsibilities within a meeting.

4. COUNSELOR CHARACTERISTICS AND TRAINING

4.1 Educational Requirements

Although it is manual guided, TSF requires considerable clinical skill to implement properly. Issues in implementation include the ability to stay focused, maintain structure within each session, and engage in constructive confrontation. Accordingly, it is recommended that prospective facilitators have a minimum of a master's degree (or equivalent) in a counseling field and a minimum of 1,000 hours of supervised counseling experience as prerequisites for competence in TSF.

4.2 Training, Credentials, and Experience Required

A master's degree in marriage and family counseling, a master's degree in social work, or a doctoral degree in clinical psychology would represent appropriate professional prerequisites for conducting TSF. Having certification as an alcohol or other drug abuse counselor is desirable but cannot substitute for basic clinical credentials. In addition, it is recommended that facilitators treat a minimum of two complete cases (minimum of eight sessions each) under supervision prior to attempting to conduct TSF unsupervised.

4.3 Counselor's Recovery Status

TSF facilitators need not be in recovery personally. Any serious TSF facilitator, however, should have read all AA/NA literature that clients will be asked to read and should be familiar with at least AA and Al-Anon meetings from personal experience (minimum of six meetings each). In addition, it is not recommended that a facilitator whose own views are unsympathetic to the primary goals of TSF (e.g., abstinence, active involvement in 12-step fellowships) seek to implement this model, for obvious reasons.

4.4 Ideal Personal Characteristics of Counselor

The best TSF facilitators have a good working grasp of basic Rogerian nonspecific, client-centered therapeutic skills, including unconditional positive regard and good active listening skills, combined with a good working knowledge of 12-step philosophy and the practicalities of getting active in 12-step fellowships. The ideal TSF facilitator is able to maintain session focus without excessive drift while also maintaining rapport. The TSF facilitator establishes a collaborative relationship with the client and utilizes confrontation in a constructive, nonpunitive manner.

4.5 Counselor's Behaviors Prescribed

The TSF facilitator will help the client:

- Assess his or her alcohol or other drug use and advocate abstinence.
- Explain basic 12-step concepts (e.g., surrender, higher power).
- Advocate and actively support and facilitate initial involvement in AA/NA.
- Facilitate ongoing participation (e.g., getting a sponsor).
- Suggest and discuss specific readings from AA/NA literature.
- Conduct two conjoint sessions if the client has an SO.
- Help the client learn to use AA/NA as resources in times of crisis and to support and celebrate sobriety.
- Help the client (time permitting) develop an initial understanding of more advanced concepts such as moral inventories.
- Conduct a termination session that helps the client assess critically his or her progress in the program.

4.6 Counselor's Behaviors Proscribed

The TSF facilitator does not:

- Conduct sessions with an intoxicated client.
- Attend AA or NA meetings with the client.
- Act as a sponsor.
- Threaten reprisals for noncompliance.
- Advocate controlled drinking or other drug use.
- Allow therapy to drift excessively onto collateral issues, such as marital or job conflict.

4.7 Recommended Supervision

Because TSF requires a relatively high level of clinical skill and the capacity to maintain focus, it is recommended that aside from the basic clinical training cited earlier, the facilitator actively participate in ongoing collegial supervision that includes observation of audiotaped or videotaped sessions. Broadly speaking, the goals of such supervision should be to:

- Provide support for the facilitator.
- Clarify treatment objectives and content (e.g., core versus elective topics).
- Help the facilitator minimize drift.

Supervisors should have a minimum of 2 years of prior general therapy supervisory experience, should be comfortable with TSF and AA philosophy in general, should have conducted TSF and other manual-guided therapies personally, and should be thoroughly familiar with all aspects of the model.

5. CLIENT-COUNSELOR RELATIONSHIP

5.1 What Is the Counselor's Role?

The facilitator's role in TSF is broadly defined as including education and advocacy, guidance and advice, and empathy and motivation. Each of these broad goals is broken down further into a series of specific guidelines or objectives. For example, guidance and support include monitoring client involvement in AA/NA, encouraging clients to volunteer for basic service work, identifying appropriate social events the client might participate in, locating appropriate meetings, and clarifying the role of a sponsor.

5.2 Who Talks More?

Clients and facilitators talk about equally in effective TSF sessions. Since TSF is an active intervention, facilitators who are passive may not succeed in maintaining focus or accomplishing basic goals. At the same time, success in TSF is dependent on monitoring client activity and reactions, which requires soliciting active client involvement in sessions.

5.3 How Directive Is the Counselor?

TSF is similar to many cognitive-behavioral therapies in that it is focused and requires the facilitator to be fairly directive while still maintaining good rapport. The TSF facilitator is directive in the following ways:

- The focus of therapy is on early recovery. The facilitator does not allow the focus to drift onto other issues (e.g., relationship or work problems) even if these are significant. The facilitator validates other concerns and helps the client develop an overall treatment plan to deal with them but maintains the focus of TSF.

- The client's reactions to assignments and meetings are considered very important. In TSF the facilitator needs to solicit specific feedback from the client.

- Each TSF session has a specific topic (core, elective, or conjoint) that includes a specific agenda to be covered. Although a given topic may require more than one session to cover, and while the facilitator needs to be somewhat flexible in his or her agenda, the facilitator must also take responsibility for controlling the content and flow of sessions.

- Each TSF session follows a set format that the facilitator is responsible for following. Again, there is some flexibility, but the facilitator does not simply follow the client's agenda.

- Every TSF session ends with the facilitator making specific suggestions to the client (recovery tasks). In addition, the facilitator is expected to make specific suggestions (e.g., which meetings to attend, how to ask for a sponsor) throughout treatment.

5.4 Therapeutic Alliance

In TSF, the facilitator is seen as an expert in interpersonal counseling techniques and as knowledgeable in the principles and practicalities of 12-step fellowships. However, in TSF the facilitator is not regarded as the primary agent of change; rather, it is the 12-step fellowship (AA or NA) that is seen as the agent of change. Accordingly, the TSF facilitator needs to conceptualize treatment as the product of a collaborative relationship and should assume responsibility for doing the best he or she can to establish that collaborative relationship. However, it is not the facilitator's goal to break down the client's denial, to provide all support needed to stay sober, to take the client to meetings, and so forth. Even in emergencies, the facilitator's role and responsibilities are limited in the TSF model. For this reason the word "facilitator" was chosen rather than therapist or counselor, as it seems to describe the role better than those labels.

6. TARGET POPULATIONS

6.1 Clients Best Suited for This Counseling Approach

TSF has been utilized in controlled outcome studies with alcohol abusers and alcoholics and with persons who have concurrent alcohol-cocaine abuse and dependency. It has been used with clients of diverse socioeconomic, educational, and cultural backgrounds and a range of maladjustment.

6.2 Clients Poorly Suited for This Counseling Approach

Individuals who have severe symptoms of addiction to cocaine or opiates, who are unemployed, and who also have no source of spousal or other family support appear to have the poorest prognosis. That is not to say that alternative treatments have proven effective with that group of individuals. When treating addiction to cocaine, it is recommended that sessions be scheduled twice a week for the first 3 weeks.

7. ASSESSMENT

The assessment session in TSF runs 1½ hours. The goals are to:

- Establish client-facilitator rapport.
- Conduct a collaborative assessment of alcohol and other drug abuse (history).
- Discuss the client's prior efforts to stop or control use.
- Discuss negative consequences associated with use.
- Share a diagnosis with the client and attempt to have it be a collaborative decision.
- Outline the TSF program.
- Attempt to get a commitment from the client to give TSF and AA/NA a try and to keep an open mind.

Assessment within the TSF model has both an informational and a motivational goal.

It is recommended that periodic alcohol tests be done either randomly or when the facilitator suspects that the client may have been drinking or using. Consistent with 12-step philosophy, no client is excluded from treatment as a consequence of drinking or using, although with some clients it may become appropriate to discuss inpatient treatment. Sessions with clients who are found to be (or who admit to being) drunk or high are terminated, and arrangements are made to get the client home safely.

8. SESSION FORMAT AND CONTENT

8.1 Format for a Typical Session

Regular TSF sessions follow the format described below. The assessment and termination sessions and the first conjoint session follow slightly different formats.

8.1.1 Review. The facilitator devotes about 10 minutes to a specific discussion of the client's so-called recovery week, including any drinking or using that occurred, any urges to drink or use that the client experienced, reactions to recovery tasks and other specific suggestions made at the end of the prior session, reactions to meeting attended, and overall progress in getting active in AA or NA.

8.1.2 New Material. The topic for each session is tentatively decided on in advance and may include a core topic, such as acceptance or surrender, or an elective topic like genograms or moral inventories. The presentation of new material often follows suggestions for reading and includes both didactic material and probing discussion to ensure that the client truly understands concepts.

8.1.3 Summary and Recovery Tasks. The facilitator asks the client to summarize what he or she got out of each session and ends with several specific suggestions (recovery tasks) that typically include reading (or listening to tape-recorded books), attending meetings, getting involved in meetings, and keeping a journal.

8.2 Several Typical Session Topics or Themes

Core topics include the assessment plus acceptance, surrender, and getting active. Acceptance has to do with discussing and illustrating Step 1 of AA and NA, which concerns accepting (as opposed to denying) one's loss of control over alcohol or other drug use. Examples of loss of control in general, and in the client's experience in particular, and the normal human reactions to it are discussed in some detail. The AA/NA view of powerlessness is discussed along with the concept of denial and the forms it commonly takes. The client is asked to identify with denial and to describe his or her own reactions to the concept of powerlessness and personal experiences with acceptance of limitation.

Elective topics include subjects such as genograms, which are used in TSF to illustrate how alcoholism and addiction are often family illnesses that continue to claim victims across generations. The client is guided in constructing a detailed alcohol-oriented and other-drug-oriented genogram, followed by a discussion of the notion of addiction as an illness. The goals are to reinforce acceptance and reduce shame.

8.3 Session Structure

As described earlier, TSF is a manual-guided treatment and as such is relatively structured. The facilitator largely determines the focus of sessions and provides specific advice from a consistent conceptual framework (i.e., the 12-step approach). The facilitator must also solicit feedback from the client, assign recovery tasks that are tailored to the individual client, and keep the focus of treatment from drifting.

8.4 Strategies for Dealing With Common Clinical Problems

Each topic within the TSF treatment manual includes a section on troubleshooting, which helps the facilitator anticipate and plan for common problems such as lateness, coming to sessions under the influence, and client resistance to new material. Most often these strategies are consistent with AA/NA philosophy and encourage the client to utilize the resources of 12-step fellowships. For example, the client who arrives drunk or high is asked how he or she will "not drink/use again for the rest of today." Clients are never punished, rejected, or scolded within the TSF model for drinking or using, since it is accepted that loss of control is the essence of their illness. However, sessions are cut short if the client is drunk/high. He or she will be strongly encouraged to call an AA or NA hotline or a recovering friend and to go to a meeting immediately. Chronic lateness or cancellations are dealt with as denial.

As a rule, the TSF facilitator places ultimate responsibility for recovery on the client. The facilitator is a guide and a source of support, but the key to recovery is always seen as active involvement in one or more 12-step fellowships. A common strategy for dealing with resistance in TSF is to ask the client to keep an open mind or just give it an honest try. The facilitator maintains a position of unconditional positive regard and acceptance of the client's illness, regardless of whatever resistance emerges.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

Strategies for dealing with resistance within the TSF model all begin with an assumption that the client has an illness that is characterized by loss of control over alcohol or other drug use, which leads him or her to want to resist accepting that loss of control. Though the only viable treatment goal from the TSF and 12-step perspective is abstinence from all alcohol or other drug use, it is expected that the client will have a hard time accepting this limitation, as anyone has difficulty accepting limitation. Viewed in this light, resistance is seen as a natural part of the course of early recovery. Indeed, the TSF facilitator should be suspicious if too little resistance is encountered (a phenomenon known as compliance).

The TSF facilitator seeks to deal with resistance through open discussion and through a process of shaping the client's behavior and attitudes. The methods employed for this shaping include consistent reinforcement of progress, acceptance of resistance, reframing of 12-step concepts (which are not dogmatically set), and compromise. The client is often asked to keep an open mind, to listen, and to try to identify with one or more of the people they hear at meetings. This is then discussed in the review part of each TSF session. The client is consistently told that he or she can accept or reject an aspect of 12-step philosophy and that the fellowship can still be a vital source of support for early recovery.

8.6 Strategies for Dealing With Crises

In TSF, the facilitator is given specific guidelines for dealing with crises ranging from suicidal ideation to spouse abuse to divorce. As a rule, only psychiatric emergencies and acute intoxication or overdose are grounds for suspending TSF. Otherwise, crises are assessed and triaged. In many instances the facilitator will direct the client to the resources of 12-step fellowships (including Al-Anon and Alateen for partners and children of clients) as a means of coping with acute stressors. Clients are encouraged to discover how ubiquitous their own problems are among people who have alcohol or other drug problems and how such issues are common topics of discussion at meetings. Indeed, the facilitator may very well be a less useful resource in this regard than the support of fellow recovering persons, many of whom have dealt with or are actively dealing with similar problems. If an emergency session is deemed necessary, the TSF manual includes specific facilitator guidelines.

8.7 Counselor's Response to Slips and Relapses

Slips and relapses are considered normal and even expected parts of early recovery, as are frequent urges to drink or use. The 12-step model regards addiction as an illness characterized by compulsion that overwhelms individual willpower. Until the client is solidly connected to a 12-step fellowship, he or she is expected to experience difficulty sustaining sobriety even with the best of intentions. The primary purpose of the review part of the TSF session is to assess the client's recovery week and to evaluate urges and slips and how the client dealt with them. This material becomes an important context in which the facilitator gradually shapes greater involvement in AA/NA. Typically, a pattern is discerned in slips. For example, it is common for a client to stay clean and sober for 1 or 2 days after a meeting and then to slip. Identifying this pattern (often with the aid of a calendar) can help to reinforce the importance of active involvement in AA/NA. In some circumstances a pattern of frequent slips despite attendance at meetings will lead the facilitator to recommend inpatient treatment.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

TSF includes a two-session conjoint program to be used whenever possible when a client is in a relationship with an SO. Like other aspects of TSF, the conjoint sessions are focused and aim to meet specific goals. They are not intended to be used as brief marital or relationship counseling, although one objective of these sessions is to help the couple assess the impact of drug abuse on the relationship. Marital therapy may be briefly discussed, and SOs' concerns, frustrations, and grievances are validated, but the facilitator also suggests that intensive relationship counseling (along with other therapies such as family therapy or sex therapy) be deferred, at least until the client has completed TSF and, preferably, 6 months of sobriety.

The two conjoint sessions deal with the subjects of enabling and detaching. Both of these concepts have their origins in Al-Anon, a 12-step program similar to AA and NA but for the affected rather than the addicted. A primary goal of the TSF conjoint program is to encourage and briefly facilitate the partner's use of Al-Anon as a resource for coping with being in a relationship with an addict and also for healing personal wounds that typically derive from that kind of relationship. Another goal is to assess initially the partner's use of alcohol or other drugs and make an appropriate referral if necessary. Finally, the goals and objectives of TSF itself and 12-step programs are outlined.

TSF includes guidelines for handling emergency calls from a partner. The approach emphasizes support and efforts to facilitate the partner's use of Al-Anon.

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Minnesota Model: Description of Counseling Approach

Patricia Owen

1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

The Minnesota Model approach is typically characterized by a thorough and ongoing assessment of all aspects of the client and of multimodal therapeutic approaches. It may include group and individual therapy, family education and support, and other methods. A multidisciplinary team of professionals (e.g., counselors, psychologists, nurses) plan and assist in the treatment process for each client. Each member of the team meets individually with the client to conduct an interview, review the client's test results, and review the questionnaire that the client completes. After the client is seen by each team member, the team meets without the client to discuss the findings and form a treatment plan that includes individualized goals and objectives. The assumption is that abstinence is the prerequisite. Treatment provides tools and a context for the client to learn new ways of living without alcohol and other drugs. This type of treatment can be employed on an inpatient or outpatient basis. The philosophy of the Minnesota Model is based on Alcoholics Anonymous (AA).

1.2 Goals and Objectives of Approach

The primary goal is lifetime abstinence from alcohol and other mood-altering chemicals and improved quality of life. This goal is achieved by applying the principles of the 12-step philosophy, which include frequent meetings with other recovering people and changes in daily behaviors. The ultimate goal is personality change or change in basic thinking, feeling, and acting in the world. Within the model, this change is referred to as a spiritual experience.

1.3 Theoretical Rationale/Mechanism of Action

This approach works by changing an addict's beliefs about his or her relationship to others and to self. This changed perspective occurs by attending meetings, by self-reflection, and by learning new coping skills. Through this process, the client's understanding about himself or herself in relationship to the self and to others is transformed.

1.4 Agent of Change

The main agent of change is group affiliation and practice of behaviors consistent with the 12 steps of AA. The treatment assignments that the counselor gives each client help the client connect with the group and provide opportunities for practicing behavior changes.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

Chemical addiction is seen as a primary, chronic, and progressive disease. It is primary because it is an entity in itself and not caused by other factors, such as intrapsychic conflict. It is chronic because a client cannot return to "normal" drinking once an addiction is established. It is progressive because symptoms and consequences continue to occur with increasing severity as use continues.

2. CONTRAST TO OTHER COUNSELING APPROACHES

2.1 Most Similar Counseling Approaches

The most similar counseling approaches are cognitive-behavioral therapy, education/rehabilitation from a physical health disorder (e.g., recovery from a heart attack), and learning to live with any chronic illness.

2.2 Most Dissimilar Counseling Approaches

Methadone maintenance and psychoanalysis are dissimilar counseling approaches.

3. FORMAT

3.1 Modalities of Treatment

Approximately 80 to 90 percent of the treatment occurs in groups; the remainder is in individual sessions. Group treatment may offer therapy focusing on seeing a broader reality; overcoming denial and gaining greater acceptance of personal responsibility and hope for change; learning about the disease and related factors; orienting to 12-step philosophy and groups (e.g., AA, Narcotics Anonymous [NA], or Cocaine Anonymous [CA]); looking at special issue groups; focusing on topics specific to clients who have special characteristics (e.g., women, elderly persons, those with dual disorders, incest survivors); and participating in recreation groups, meditation groups, work task groups, groups for individuals to tell their stories and receive feedback, and groups where members review their behavioral homework assignments. Individual sessions are used for reviewing progress and addressing issues that may be too sensitive or unique to be dealt with routinely in a group setting.

Typically, the counselor schedules individual meetings one to three times a week, more frequently toward the beginning of treatment and less frequently toward the end of treatment. The counselor helps the client integrate all of his or her group experience and individual work, teaching the client how this knowledge applies to the 12-step philosophy. Individual sessions are used to review the treatment assignments with the client and to give new assignments. For example, after the treatment team has established the client's goals and methods, the client and counselor meet. Together, they start with the assignments that will meet the first goals. During the next individual session, the counselor and client may review those assignments to determine whether they were helpful and whether the goal was met. If so, they move to the next set of assignments to work on the next goal. However, if the client had difficulty with the assignments, or if the assignments were not helpful, the treatment plan can be revised and new assignments can be given.

Unscheduled individual sessions are conducted to resolve difficulties the client may have in the treatment setting or with external issues (e.g., family, legal system). For the client whose functioning level is low because of cognitive or emotional impairment, the counselor may meet more frequently with the individual for short sessions (e.g., 15 minutes) to help the client stay on track with simple daily goals and to reevaluate status.

3.2 Ideal Treatment Setting

The ideal treatment setting is residential, as this environment most easily conveys dignity and respect for the individual and provides grounds and physical space for solitude and reflection. This model can, however, be applied in any setting.

3.3 Duration of Treatment

In a residential setting, the typical length of stay is 22 to 28 days. On an outpatient basis, the typical length of treatment is 5 to 6 weeks of intensive therapy (3 to 4 nights a week, 3 to 4 hours a session) followed by 10 or more weeks of weekly aftercare sessions.

3.4 Compatibility With Other Treatments

This approach is compatible with psychotropic medication monitoring, individual psychotherapy, and family therapy.

3.5 Role of Self-Help Programs

Involvement in self-help groups (AA, NA, CA) is considered critical for long-term abstinence. In some cases, involvement in related self-help groups (e.g., Women for Sobriety) may be acceptable. During primary treatment, the goal is to expose clients to 12-step programs so they can begin to see how they function and to feel comfortable in them. After primary treatment, frequency of meetings depends on the individual. If a client is functioning relatively well and has a good support system, attendance one to two times a week may be recommended; for those whose hold on recovery is more tenuous, daily meetings may be recommended. Clients are urged to join groups that are most specific to their drug of choice.

4. COUNSELOR CHARACTERISTICS AND TRAINING

4.1 Educational Requirements

A bachelor's degree is required, but some treatment programs accept a counselor who has a high school diploma, certification, and experience. Ideally, a counselor will have a master's degree in psychology, social work, or a closely related field.

4.2 Training, Credentials, and Experience Required

Chemical addiction counselors take a State credentializing examination and receive certification. Some States now require licensure. Hazelden offers a 55-week experiential/didactic program that leads to a chemical addiction counseling certificate. Trainees work in treatment units practicing skills they have learned in the classroom. Hazelden has an affiliation with the University of Minnesota. Hazelden also offers classroom chemical addiction counselor courses in Texas and Florida.

4.3 Counselor's Recovery Status

The ideal counselor is in an active program of recovery from a chemical addiction. Understanding and practicing the 12-step philosophy (e.g., self-help group attendance, AA/NA, Al-Anon, CA) in personal life are essential. All counselors must demonstrate good chemical health. Nonrecovering counselors can also do quite well.

4.4 Ideal Personal Characteristics of Counselor

A counselor should:

- Be tolerant and nonjudgmental of client diversity.
- Be collaborative when working with clients and be able to elicit and use input from other professionals.
- Be flexible in accepting job responsibilities (e.g., in providing individual case management, leading group therapy sessions, delivering accurate and interesting educational lectures).
- Have good verbal and written communication skills.
- Have personal integrity.
- Convey compassion to clients.

4.5 Counselor's Behaviors Prescribed

The counselor must be able to:

- Assess a client's addiction.
- Compile and synthesize information about a client from other professionals, referents, and family members.
- Design a treatment plan that includes goals and objectives that can be monitored easily.

- Assign goals and objectives and periodically evaluate progress toward them by observation and discussion.

- Point out a client's strengths and barriers to recovery.

- Describe observed progress toward goals.

- Elicit client commitment and behaviors toward change.

- Trust a client's ability to change and convey information.

- Summarize, paraphrase, or reflect a client's statements back to him or her; probe for further information.

- Listen to where a client is in the process of recovery and employ treatment or counseling methods accordingly.

- Offer personal disclosure within appropriate boundaries (e.g., recovery status).

4.6 Counselor's Behaviors Proscribed

The counselor must not:

- Break confidentiality.

- Provide any medications, even over-the-counter types.

- Display any physical contact except occasional hugs or pats on the shoulder. (This limited physical contact should occur only with the client's permission or request and be conducted in a public place.)

- Confront a client unnecessarily (i.e., no bullying, shaming, or humiliating).

- Establish a personal relationship outside the treatment setting.

- Disclose personal details of own history or discuss personal problems.

4.7 Recommended Supervision

The counseling model is established so that ongoing supervision is naturally obtained from the supervisor and colleagues during the multidisciplinary team meetings. Clients are discussed and reviewed on a weekly basis, and each counselor receives ongoing feedback about his or her work. Ideally, the counselor receives individual supervision at least monthly, where patterns of types of clients and any problems the counselor has can be discussed.

5. CLIENT-COUNSELOR RELATIONSHIP

5.1 What Is the Counselor's Role?

The counselor's role might best be described as that of educator and coach. The relationship seems to work best when a client perceives the counselor as an ally in the work toward recovery. In other words, the counselor is an important resource in the client's recovery, not the one who is responsible for the recovery.

5.2 Who Talks More?

It depends on the goal of the session. Generally, the client talks more than the counselor does. However, if the counselor is giving goals and objectives, the counselor will do most of the talking.

5.3 How Directive Is the Counselor?

A good counselor will be more or less directive, depending on client characteristics and stage of treatment. This form of treatment is more directive than many types of therapy (e.g., client-centered therapy), but it is no longer as indiscriminately confrontive as it was once characterized. The counselor will typically be direct in stating "this is what I see about you," but usually not until he or she has elicited the client's perception and built a rapport. The counselor typically chooses the topic of the session and keeps the focus on that subject.

There is a misconception that the Minnesota Model is, or needs to be, hard-hitting confrontation. This is unfortunate, as the method of direct or harsh confrontation may in fact be detrimental to some clients, particularly those whose self-esteem is already compromised. This is often true for elderly persons, women, people who are depressed, and people who are just realizing they are alcoholic/addicted and are feeling the painful consequences. Shaming clients and using punitive treatment methods do not have a place in the Minnesota Model.

5.4 Therapeutic Alliance

In this model, the counselor is seen as a colleague or partner in the recovery process, the one who has expertise. The counselor aligns with the client: listening, retaining confidentiality, demonstrating knowledge, observing the client without judgment or shaming, and offering encouragement and support. A therapeutic alliance (TA) can be poor if the client perceives the counselor as an authority figure and rebels. The counselor typically attempts to avoid a power struggle and intentionally places responsibility for behavior on the client. At Hazelden there are no locked units. In fact, original artwork adorns the walls, the furniture is noninstitutional, and clients are free to walk the trails of the woods.

Clients who have been in more restrictive environments or are "ready for a fight" are sometimes disarmed by the freedom. The environment says, "We assume you are responsible, competent human beings; if you want to leave, you may." If the client focuses anger or blame on the counselor for his or her alcoholism/addiction or need for treatment, the counselor may choose to keep a lower profile or play a background role in the client's recovery. In this case, treatment assignments would have the client gather information from family, friends, or staff whom they choose to trust, rather than from the counselor (if that is where the rebellion is placed). Usually this approach defuses the issue.

A poor TA can also occur if a client becomes overly dependent on the counselor, placing his or her success in the counselor's hands. In this case, the client may claim to be unable to stay sober without constant attention from the counselor and may have repeated crises. If the counselor attempts to set limits, the client may "triangulate" the staff by going to other staff members. The counselor is likely to work toward improving this TA by:

- Talking directly to the client about his or her neediness and ways to work together to help the client feel more secure in the recovery process.

- Encouraging the client to include more peers in his or her recovery process (e.g., using the homework assignments to help the client make these connections).

- Referring the client for psychological consultation to see if he or she is becoming too overwhelmed by emotional issues that are arising as chemicals are leaving his or her system.

- Continuing to offer support and reinforcement for even small successes so the client begins to "own" his or her recovery process.

6. TARGET POPULATIONS

6.1 Clients Best Suited for This Counseling Approach

The following individuals are well suited for this approach:

- Adolescents or adults who have transient intellectual impairment at most.

- People with average or better intellectual ability and at least sixth-grade reading ability.

- Alcoholics or polydrug users.

- People who are dually diagnosed if the psychiatric disorder is stable or not predominant in the clinical picture.

- People who have or develop at least moderate motivation and willingness to change. (Although many come to treatment with some resistance, most will be able to engage in the treatment process within 5 to 10 days. If they cannot, they may be discharged.)

6.2 Clients Poorly Suited for This Counseling Approach

Those not suited for this approach include the converse of the above, as well as individuals who are seeking methadone maintenance, those with poor reading ability or memory impairment, and those not motivated to change.

7. ASSESSMENT

The initial assessment generally takes 5 to 7 days. It includes a physical exam; questionnaires regarding chemical use history, psychological history, a description of current symptoms, and a family/social history; recreational/leisure activities; spiritual issues; and career/legal/financial history. The client is also given MMPI, Shipley, Hartford, and Beck evaluations. Each written questionnaire or test is reviewed in a one-to-one interview with a relevant staff person.

Assessment during treatment is done by reviewing homework (written), by conducting interviews, and by observing the client. Homework assignments are a critical part of the treatment process. Depending on the client's needs, assignments may include activities like reading a pamphlet or chapter in a book and discussing it with a peer, holding a small group discussion on a topic, keeping a journal, asking a peer for help in any way, spending enjoyable time with peers, writing a detailed history of personal drug use and consequences, answering questions that help personalize the 12 steps, and so forth. By observing the client and reviewing his or her assignments, the counselor can obtain information about the client's ability to progress in recovery. Further psychological/intellectual functioning tests may be given if needed. Major domains assessed depend on the individual. Typically, progress is assessed by evaluation progress toward the established individual treatment goals. After treatment, clients are typically sent evaluation questionnaires at 1 month, 6 months, and 12 months. Major domains assessed are chemical use, self-help attendance, and quality of life.

8. SESSION FORMAT AND CONTENT

8.1 Format for a Typical Session

Session structure depends to some degree on each counselor's style. In general, the counselor:

- Elicits any new information about progress from the client (e.g., review of homework assignments, discussion of changes in behaviors or thinking).
- Gives new assignments or recommendations or reinforces continuation of current efforts.

8.2 Several Typical Session Topics or Themes

In the first several sessions, the theme is assessment. The counselor determines the topic and basic structure and then reviews, with the client, the written information the client has provided about an aspect of his or her life. The purpose of these sessions is to clarify and expand on the information given to provide a more thorough assessment.

In the goal-setting session, the counselor tells the client the goal that has been recommended for him or her, based on the information he or she has provided in the assessment phase. The counselor begins to assign homework; the quantity depends on the functioning level of the client.

During progress review sessions, the counselor continues to meet with the client periodically to review progress and give new assignments.

During client-initiated sessions, the client typically requests one or more sessions with the counselor to ask for help in dealing with issues that arise during the course of treatment. These are typically problemsolving sessions.

The counselor and client discuss plans for discharge during aftercare planning sessions, including living situation, return to work, referrals to AA and other community resources, and ongoing goals the client will continue to work on.

8.3 Session Structure

Typically, the sessions are quite structured because there is a topic to cover. Client-initiated sessions tend to be less structured.

8.4 Strategies for Dealing With Common Clinical Problems

The problem behavior is pointed out to the client. When applicable, the problem is put in the context of the 12-step philosophy for possible resolution. For example, a client may be asked, "I know you are working on your anger and need to control. Does this situation relate to that?" Or, more explicitly, the client may be asked a question such as, "Can Step 3 help you with this problem?" Depending on the nature and severity of the problem, the responsibility for change is given to the client (e.g., "What do you need to do to get here on time?"). If the client is unable or unwilling to describe methods for change, the counselor may say, "How would it work if you did _________?" If the client still cannot commit to making the changes, the counselor may recommend that he or she talk to peers about the problem and elicit recommendations for change. If the client is unwilling to do the above, or if the problem behavior continues, the client is seen by the counselor's supervisor or the clinic director. Other sources of the problem may be explored (e.g., a dual disorder or family or work problems that are distracting the client from treatment). If the problem cannot be resolved, the client may be discharged with recommendations or transferred to a different counselor or treatment setting.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

Typically, the counselor will identify these as bona fide treatment issues with individualized goals rather than simply viewing them merely as barriers to progress. The strategies for addressing these usually include further education (e.g., reading, reflecting, and writing; talking with peers). These may be used as examples of the treatment principles the client is learning (e.g., Step 1).

8.6 Strategies for Dealing With Crises

The counselor responds as any therapist would, by meeting with the client to determine the nature and extent of the crisis and proceeding accordingly. The client may be referred to another type of treatment instead of or in addition to the current treatment. In addition, the client will be encouraged to turn to peers for support to serve as practice and reinforcement for learning new ways of coping without chemicals. This may be used as an example of the treatment principles the client is learning (e.g., Step 3).

8.7 Counselor's Response to Slips and Relapses

First, the client would be taken to detox if still under the influence. Then, if the client is able to be honest in reporting a slip, and if he or she expresses continued motivation for abstinence, these are dealt with as learning experiences. The counselor may use these to illustrate the power of addiction (Step 1) and will work with the client to identify triggers for relapse and how to cope with them. In severe cases, the client may need to go back to detox and return to treatment to focus on a revised treatment plan. If the client continues to relapse and expresses no motivation to change, the counselor would assess (or refer for assessment of) undiagnosed comorbidity (e.g., depression, organicity). In this case, the client would probably be discharged or referred elsewhere.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

At the beginning of treatment, family members are asked to fill out a detailed questionnaire about the client's alcohol and other drug use and the resulting consequences. The counselor will probably have one or more discussions with family members during the assessment phase to gather more information. The family is invited to come to a separate family program where they will learn more about addiction and what changes they can begin to make in their lives. Toward the end of treatment, there may be a family conference where the counselor, the client, and the client's family meet to discuss outstanding issues and review goals for discharge. For many families this is just the beginning, as they will be referred to marital/family counseling after treatment. Family and friends are always referred to Al-Anon. In a time of crisis, the counselor will sometimes call family members to elicit their suggestions and involvement.

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A Counseling Approach

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1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

This approach to counseling is based on the belief that a condition of susceptibility to chemical addiction exists prior to the first use, sometimes referred to as a "genetic predisposition." It is also based on the belief that chemical addiction is a disease repeatedly reinforced by self-judgment; therefore, it is a disease of self-judgment.

This model views addicts and alcoholics as individuals chronically addicted to chemicals in spite of their attempts to change. They are in a vicious cycle of use, self-judgment, and avoidance that is repeated time and again. The model focuses on three elements of the cycle:

1. Chemical use.
2. Self-judgment.
3. Avoidance behaviors.

The approach to counseling is strongly based on the 12 steps of Alcoholics Anonymous (AA).

The three elements of the addictive cycle are impacted by a process created by using:

1. A therapeutic environment.
2. A thorough assessment.
3. A group process.
4. Education.
5. Self/peer assessment.

All five items are incorporated into a therapeutic process, which begins with the first contact.

The creation of an environment that supports the therapeutic process is essential to this approach. Clients must be provided with an opportunity to explore their self-judgments without fear of the judgment of others. They must feel they are listened to with empathy and respect. In earlier models of this approach, the counselor was the only one who possessed so-called counselor characteristics. Although this element is still critical, it now applies to the whole multidisciplinary team, a staff of professionals who are naturally therapeutic.

The counselor conducts an initial assessment, identifies the presenting problem, and, if indicated, schedules the client for treatment.

A thorough psychosocial assessment is conducted, and identified blocks to treatment or problems are noted. The counselor begins the bonding with the client during the assessment process. All counseling skills come into play. The counselor then prepares a therapeutic or treatment plan (i.e., the change model) to help the client deal with those identified problems or blocks that will prevent response to the treatment process.

The client follows a simple change model that closely aligns with the 12 steps of AA.

Model	AA Step
Identify the problem	Step 1
Develop trust (renewed hope)	Steps 2 and 3

Model	AA Step
Ventilate	Steps 4 and 5
Gain new insight	Steps 6 and 8
Change behavior	Step 7 and Steps 9 through 12

Clients are guided through the first 5 steps of the 12-step model and receive educational materials on the remaining 7. The first five steps help clients focus on the goals of this approach.

Step 1. Acceptance is clearly necessary in identifying the problem.

Step 2. The perception is a return to a sense of hope.

Step 3. Turn over to a new behavior.

Steps 4 and 5. Facilitate ventilation or catharsis and give clients new insight and, as a result, new behaviors.

After completing the treatment process, clients are referred to continuing care groups that meet once a week. Additional meetings can be scheduled if indicated.

Psychotherapy or marital counseling can also be a part of the continuing care process, if appropriate.

Twelve months of continuing care and a minimum of three AA meetings a week are a part of the treatment program.

1.2 Goals and Objectives of Approach

Goals. Identify the primary problem as chronic addiction to mind- or mood-altering chemicals.

Gain a renewed sense of hope; come to believe wellness is possible.

Experience lifestyle changes that promote a renewed sense of self-esteem by practicing healthy emotional management and increasing personal responsibility.

Objective. Identify the problem.

No one can change what cannot be seen. The program leads clients through a sequence of tasks that are designed to help identify the problem.

- Life story.
- Ten consequences.
- AA first step.

All of these tasks are shared with staff and peers.

Strategies/Techniques. The counselor asks the client to look at a mirror image that he or she has created through drug use (i.e., self-discovery). All of the tasks will be reviewed with or by the counselor and peers. The counselor may choose to have the client review them in a one-on-one session first. This session can provide emotional insulation from a more public sharing with a group of peers, but it is not intended to take the place of receiving peer feedback.

Objective. Develop trust.

A common philosophy that is shared by all staff members is the basis for helping the client develop trust. Clearly written policies and procedures that are understood by all the staff members facilitate trust and create an environment of consistency. Beginning to trust brings a renewed sense of hope.

Strategies/Techniques. The counselor can use all the counseling skills to facilitate this objective. The initial assessment, or in some programs the psychosocial assessment, is where this development of trust with the counselor begins. Attending, empathy, genuineness, and honesty are some of the counselor's tools. The psychosocial assessment is an excellent opportunity for the counselor to create a therapeutic relationship with the client. The counselor should make it a joint effort to explore the different areas of the client's life. It must be more than a process to collect data.

Objective. Experience a catharsis/ventilation.

The client must be given the opportunity to begin looking at and bringing out the secrets that are the bases for his or her self-judgments. It is the primary purpose of the fourth and fifth steps of AA. Self-disclosure is cathartic and can lead to self-discovery.

Strategies/Techniques. The counselor should guide the client to deeper levels of self-disclosure through the use of treatment plan objectives and helping skills and must stay focused on those areas related to the addiction or the identified blocks that prevent the client from responding to the program. Remember that catharsis/ventilation does not necessarily mean crying. For example, ask the client to share with the group five words that describe how his or her parent feels about having a child in treatment. Then have the group help the client explore this issue.

Objective. Gain new insight.

It is important that this be the client's self-discovery and that he or she begins to see the consequences of his or her behaviors, the defects of character, and the people who have been harmed. This insight, facilitated by Steps 4 and 5 (catharsis), leads the client to Steps 6 and 8 (insight).

Strategies/Techniques. Treatment plan objectives, group tasks, and facilitated exploration of the issues identified by the client can lead to new insight. Have the client share one of the items from his or her list of 10 consequences with the group and ask for feedback. Have the client read the story from the *Big Book of AA* that is closest to him or her and share with the group. Ask each client to share a secret not previously shared and tell the group what he or she has learned.

Objective. Change behavior.

The program must contain activities designed to facilitate learning of new behaviors. Being assigned to a small group helps clients learn to use groups as support. The buddy system used in some programs helps clients begin to learn the behavior of using a support system outside of themselves.

Strategies/Techniques. The counselor should monitor the client's behavior throughout the treatment process, frequently giving feedback. This is the beginning of learning to use a sponsor, which is deemed critical by most AA members. Treatment plan tasks can require the client to try using a new behavior to cope with certain problems.

1.3 Theoretical Rationale/Mechanism of Action

By facilitating the client in experiencing a change in the way he or she believes, feels, and behaves, this approach is implemented with the following premises:

1. What the client believes is the basis for his or her self-judgment. Self-esteem is not taken away by others. It is taken away by self-judgment based on the client's belief system.

2. A key to this approach is the premise that negative feelings that are not dealt with do not go away. These avoided feelings become the basis for the loss of self-esteem.

3. Successful new behavior is the basis for a renewed positive sense of self.

Change Model

1. Identify the problem as chemical use.

2. Gain a sense of trust.

3. Ventilate feelings.

4. Gain new insight into life and behaviors.

5. Change behaviors.

1.4 Agent of Change

The primary agent of change is the combination of spirituality, the individual, and the treatment process (the therapist, the group, the 12 steps, and the treatment program).

1.4.1 Spirituality. In general, spirituality is defined as a healthy relationship with the things and people who are valued. By helping the client improve his or her relationships, spirituality becomes a primary agent of change.

1.4.2 The Individual. Drug addiction, which is classified as a disease, requires three components to meet the definition:

1. An agent or drug.
2. A host or individual.
3. An environment.

If any one of the three components is removed, the chronic progression of the disease is interrupted. By focusing on the individual, he or she becomes a primary agent of change.

1.4.3 Treatment Process. The treatment process is a primary agent of change in this counseling approach; the therapeutic community, which encourages honesty, openness, and bonding, becomes a primary agent of change.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

This model is based on the belief that drug addiction is a disease. Most probably the client is genetically predisposed. Certainly the client is biochemically altered. The client is also psychologically affected by the emotional mismanagement and distortion of the defense systems. By inhibiting or supplanting the social coping skills of the client, drug addiction has a disastrous effect on all social areas. Drug addiction is a biopsychosocial disease characterized by physical deterioration, a prevailing sense of hopelessness, and severe emotional isolation. The client also experiences a gross violation of his or her value system.

2. CONTRAST TO OTHER COUNSELING APPROACHES

2.1 Most Similar Counseling Approaches

Counselors who have been fortunate enough to be trained in a program that is based on an interdisciplinary philosophy will have the benefit of both counseling psychology and the 12-step model. Hazelden would probably be the closest. All counselors trained at both the Navy Alcohol Treatment Specialist School and the Johnson Institute during the 1970s would share this approach to counseling.

2.2 Most Dissimilar Counseling Approaches

These include:

- Approaches that are not based on total abstinence.
- Approaches that do not deal with feelings.
- Approaches that do not use the 12 steps of AA.

3. FORMAT

3.1 Modalities of Treatment

This approach primarily uses the small group process. Individual sessions are used when warranted.

3.1.1 Individual Sessions. The individual session is used in the assessment phase at the beginning of treatment and for individual planning sessions during the course of treatment. Some individual counseling may be offered to give the client an emotional insulation. A client's first attempts at being more open will be frightening. By sharing with a counselor beforehand, the client may be able to disclose within his or her group more readily.

- Goals. These include individual planning, clarification, reassessment, or help in exploring a client's highly traumatic issues.

- Process. The individual session can be scheduled at the request of the counselor or the client. The goal is stated, and the process begins. The process is dictated by the goal, but all have a beginning, a middle, and an end.

3.1.2 Group Sessions. All activities are designed to have the client learn to use small groups as a support system. Each group remains as autonomous as possible to encourage the client to be more open and share at a deeper level. This also prevents triangulation and defocusing. It is easier to hide in a large group.

- Goals. Help the client learn to use small groups for support, for feedback, and for communication skills, as task oriented or process oriented.

3.1.3 Other Group Sessions. Other special groups can be utilized for topics like grief or sexual abuse and other types of physical and emotional abuse. These are sometimes called special treatment population groups or focused groups.

- Goal. To help the client use peers who have a similar experience for support.

- Process. Having clients who share a significant experience facilitates the bonding and thus the self-disclosure or catharsis.

3.2 Ideal Treatment Setting

The ideal setting would be to match the treatment to the individual. This approach works best in inpatient and outpatient programs; however, the approach can be utilized as a base in any setting. Some of the activities would be altered, but the process would be the same.

1. Identify the problem.

2. Develop a sense of trust and hope.

3. Ventilate.
4. Gain new insight.

5. Change behavior.

3.3 Duration of Treatment

The ideal format for this approach is a small group. The duration would be 1½ hours (±15 minutes). The group should number between 8 and 10 people (the number could affect the duration). Each client's level of functioning would also have an impact on the duration.

The use of open-ended groups in alcohol and other drug counseling is almost universally utilized and is probably the best format. Clients should attend the primary group for at least 6 weeks. This could include 2 to 3 weeks of inpatient treatment and 3 to 4 weeks of outpatient treatment. The number of sessions would generally vary with the settings. Key, however, is to include 12 months of continuing care.

There have been some studies suggesting that it takes 21 days (3 weeks) to let go of old attitudes and 21 days to develop new ones. This premise would strongly indicate the need for a program with a 6-week duration.

Inpatient groups should have one primary counseling group every day. Outpatient groups should meet once a day, four times a week.

3.4 Compatibility With Other Treatments

This approach would be compatible with family programs, diversion programs, probation and correctional programs, adolescent programs, and driving under the influence programs, within a broad range of treatment settings.

This counseling approach would not be compatible with programs that used psychoactive drugs or programs that did not focus on abstinence as a primary goal.

3.5 Role of Self-Help Programs

This approach is a balanced integration of 12-step programs and a solid counseling approach. NA, AA, and other self-help groups are key elements in this approach. Since NA and AA have abstinence as a primary goal, both are a part of the counseling approach. Using attendance at meetings as part of the treatment plan sets the groundwork for using meetings as a continued support after treatment.

4. COUNSELOR CHARACTERISTICS AND TRAINING

4.1 Educational Requirements

The educational requirements for the counseling approach would ideally include:

- Bachelor's or master's degree in either the behavioral sciences or the counseling psychology fields.
- Certification by a State or national certifying organization.
- Specific training in working with special treatment populations.

4.2 Training, Credentials, and Experience Required

Counselors should have a certificate in chemical addiction education and should be certified as addiction counselors by a State or national organization. Counselors should also have a minimum of 3 years of experience.

All counselors using this counseling approach need:

- Comprehension of the addictive process and how it is to be treated.
- A comprehensive curriculum of the addictive process and how it is to be taught.
- A viable, realistic opportunity to demonstrate knowledge, comprehension, and expertise to practice the counseling skills in a classroom setting with clients in a supervised practicum.
- A method of analysis and an opportunity to apply it.
- A method of analyzing client data and the opportunity to apply it.
- The opportunity to demonstrate an ability to synthesize knowledge, comprehension, application, and analysis into a viable approach to counseling.

4.3 Counselor's Recovery Status

The counselor need not be recovering, but counselors who are not in recovery must have a demonstrated understanding of the disease. Counselors who are recovering might be quicker but not necessarily better.

4.4 Ideal Personal Characteristics of Counselor

To utilize this counseling approach, an individual needs some innate helping skills. He or she must have the ability to touch people emotionally.

To utilize this approach successfully, the counselor should have the following characteristics:

- Empathetic understanding.
- Respect and acceptance for others.
- Sincerity.
- Good timing.

4.5 Counselor's Behaviors Prescribed

The counselor needs to be able to facilitate clients' exploration of their disease. He or she must be:

- Tactful, yet confrontive.
- Evaluative.
- Emotionally present, yet objective.

4.5.1 Comment/Confrontation. Confrontation is the most confused and misused of the counseling skills. When it comes to misused skills, it is probably second only to doing therapy without the necessary skills to do it correctly. Confrontation must be done with respect for the client. It is a tool, not an end item. The avoidance behaviors must be confronted; the elephant in the living room must be brought to someone's attention. If the counselor's empathy is accurate, he or she will know how to gauge the confrontation. Confrontive therapy can be long and expensive and generally does not work with addicts and alcoholics.

4.6 Counselor's Behaviors Proscribed

4.6.1 Judgmental Behavior. If the counselor does not believe addiction is a disease, or he or she has personal beliefs that go against the program's philosophy, the counselor needs to work elsewhere.

4.6.2 Coaddiction. If the counselor has enabling behaviors that shortcut the process or enable the client's avoidance system, the counselor should either find another helping field or get help.

4.6.3 Dishonesty. If the counselor cannot be honest with his or her peers and with the clients, the counselor should either find another helping field or get help.

4.6.4 Fear. If the counselor is frightened by addicted clients, he or she cannot help them.

4.6.5 Feedback. If the counselor cannot work as a part of a team and accept and consider feedback, he or she will prevent clients from receiving the best possible therapy.

4.7 Recommended Supervision

Supervision works best when it is provided by a trained staff member who is outside of the management team. Too many programs use the clinical supervisor as the program supervisor. The combination of direct supervision and case review gives the counseling staff the most credible supervision and feedback.

4.7.1 Direct Supervision. Frequent and rotational direct participation in counseling groups and sessions gives the supervisor the opportunity to evaluate the counselor's skills and his or her application of them.

4.7.2 Case Review. Counselors should follow a schedule of case presentation. They can present one on one to the supervisor or in a group of their peers.

5. CLIENT-COUNSELOR RELATIONSHIP

5.1 What Is the Counselor's Role?

The counselor's role is to facilitate, that is, to be a teacher, coach, peer, and even adviser.

5.2 Who Talks More?

Because the bulk of time is spent in group process and the client's peers are utilized, most of the talking is done by the client. This would depend somewhat on the style and personality of the counselor.

5.3 How Directive Is the Counselor?

The amount of direction by the counselor depends primarily on where the client is in the treatment process and who the client is emotionally.

5.4 Therapeutic Alliance

The client must trust the counselor. The counseling characteristics and their application are key to having a good relationship with the client. If the counselor frequently checks in with the client and involves the client in the planning of the treatment, the quality of the relationship will be maintained. When the relationship is poor, the counselor should ask the client to help get the relationship back on track.

6. TARGET POPULATIONS

6.1 Clients Best Suited for This Counseling Approach

The general population and its subgroups are suited for this approach. All forms of chemical addiction are suited for this approach, including alcohol and tobacco.

6.2 Clients Poorly Suited for This Counseling Approach

Individuals who have significant organic brain damage or a significant psychiatric or psychological block to insight based on a comprehension of behaviors and their resultant feelings are not well suited.

7. ASSESSMENT

This model uses a comprehensive psychosocial assessment tool that reviews:

1. Initial assessment/problem evaluation. The presenting problem is often the basis for the initial assessment. This first contact reviews a client's current status and is the basis for an initial diagnosis.

2. Physical/medical history. A physical examination of the client's medical condition is conducted, and a physician takes a medical history.

3. Nursing assessment. The client's mental status and emotional and psychological history are tested, including any evaluated blocks to treatment.

4. Spiritual assessment. The client's relationship with his or her spiritual connection and his or her religious experiences are reviewed, including any possible block to treatment.

5. Psychosocial assessment. The client's mental status and emotional and psychological history are assessed, including any evaluated blocks to treatment.

6. Social/chemical background. This includes chemical history, activities, financial, vocational, military, legal history, sexual history, marital history, losses, emotional behavior, and family of origin.

7. Clinical formulation. The clinical formulation is the bringing together of a description of the identified behaviors and problems and formulating them into a behavioral and problematic description of the client.

8. SESSION FORMAT AND CONTENT

8.1 Format for a Typical Session

The format would be a group session. All the assigned members of the group would be seated in a circle. The session would begin with a reading of group rules and possibly a reading from a daily meditation book.

A session could have a purpose or be open to the group need. Some clients may have scheduled tasks. The counselor may ask a group member to report on a previously discussed issue. Some group sessions will have an educational component, while others may be more task oriented.

All sessions would be closed in a specific manner. A closure activity, normally agreed on by the group, would add a specific emotional and symbolic closure of process.

8.2 Several Typical Session Topics or Themes

As a facilitator, the counselor may suggest a topic or point the group toward certain tasks. The session may be predesignated, assigning a certain day to a first-step group.

8.2.1 First Step. The client is asked to write a first step related to his or her drug use following the guidelines of AA, usually with a form that asks for answers to specific questions. The client is asked to read this to the group and receive feedback. More than one first step may be read in a session.

8.2.2 Life Story With Feedback. The client writes a life story using a guidesheet that leads him or her through important/significant life events. In some programs the reading may be done in a leaderless group. The peers are then asked to fill out a feedback sheet. The following day, in regular group, under the supervision of the counselor, the client's peers offer supportive feedback.

8.2.3 Secrets Group. (This is a very brief description of the process.) The secrets group usually asks the client to share a secret not previously shared. One format asks the group members to write a secret on a slip of paper and put it in a bowl. The bowl is then passed around the group, each member taking out a secret and reading it aloud to the group and then making a comment. All group members who want to comment are then given a chance to share how they feel about this particular secret. It gives the writer of the secret a chance to receive feedback and still keep the secret.

8.2.4 Typical Group. The session begins with a group member reading the rules. A round-robin may be used, going around the group in order. Issues can be identified and in some cases worked on. Before closing, the counselor sees where each member is in the group. Usually some ritual is used, like a group hug, a chant, or a prayer.

8.3 Session Structure

Sessions are generally not highly structured, which does not preclude the use of structure if indicated.

The counselor may choose to use an experiential exercise to address an issue of common concern or to get the group moving. The ideal group would be self-starting and possibly task oriented.

8.4 Strategies for Dealing With Common Clinical Problems

Most logistical and clinical problems are dealt with as group issues. However, some problems may be dealt with one on one or with the clinical team, if available. Whatever happens in group or is brought to the group becomes a workable issue.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

8.5.1 Peer Feedback. The counselor can use the group to confront, support, or give feedback on particular issues. An issue may come up in group; after the client processes it, the counselor may ask how the group feels about it, the process, how their peer handled it, and so forth.

8.5.2 Staffing. The counselor can ask the client to receive feedback from the clinical team involved in his or her case. Staffing may also be a part of the client evaluation system. The goal is to resolve the issue in a therapeutic manner. Some programs require the staff to conduct a staffing as a part of assigning poor progress. Staffing is usually feedback from the clinical team.

8.5.3 Conjoint Sessions With Family Members. These sessions are usually used to ensure that all members of the family are aware of the continuing care plan. They also clarify any issues that may be problems in posttreatment.

8.5.4 Group Tasks or Experiential Exercises. Group tasks are usually from a specific objective listed in the treatment plan. Experiential exercises are normally for an issue that is applicable to the whole group.

8.6 Strategies for Dealing With Crises

The primary strategy for dealing with crises is good training and a good clinical relationship with the client, guided by sound policies. The counselor and the facility in which he or she works should have clear policies regarding the management of a crisis. Good training in this area is needed, coupled with the knowledge of available resources.

8.7 Counselor's Response to Slips and Relapses

The counselor should use a nonjudgmental attitude in a confronting manner to focus the client on the disease. With the advent of the relapse prevention model, a special track may be utilized. Repeated slips also could be grounds for terminating the counseling or treatment process. In most inpatient facilities, when a client uses alcohol or other drugs while in treatment, he or she is asked to leave on the grounds of low motivation. In other facilities, the client may be asked to sign a nonuse contract, and the relapse is used as a clinical issue.

A slip or relapse can be another catalyst to help the client identify the problem.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

This counseling approach presumes a concurrent family education and treatment program. The success rate increases significantly when family members are involved. A questionnaire should be sent to those significant others (SOs) considered to have the closest association with the client. The answers on the questionnaire assists the counselor in confronting the denial system and also helps stop the triangulation often used by clients to continue their avoidance system.

SOs who are themselves in recovery from coaddiction will provide a supportive, nonenabling support group for the client after treatment. The family who is in recovery together has a better chance.

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A Psychotherapeutic and Skills-Training Approach to the Treatment of Drug Addiction

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1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

This approach integrates psychotherapeutic and coping skills-training techniques with abstinence-based addiction counseling. The primary goals of treatment are to enhance and sustain patient motivation for change, establish and maintain abstinence from all psychoactive drugs, and foster development of (nonchemical) coping and problemsolving skills to thwart and ultimately eliminate impulses to "self-medicate" with psychoactive drugs. The approach combines cognitive-behavioral, motivational, and insight-oriented techniques according to each client's individual needs. The therapeutic style is empathic, client centered, and flexible. Strong emphasis is placed on developing a good working alliance with the client to prevent premature dropout and as a vehicle for promoting therapeutic change. The counselor attempts to work with and through rather than against a client's resistance to change. Aggressive confrontation of denial, the hallmark of traditional addiction counseling, is seen as counterproductive and antithetical to this approach. Group and individual counseling are delivered within the context of a structured yet flexible multistage outpatient treatment program that also includes psychoeducation (PE) for both the primary client and his or her family; supervised urine testing to encourage and verify abstinence; and, where indicated, pharmacotherapy for coexisting psychiatric disorders. Patient participation in self-help is encouraged but not mandated, and accepting the identity of addict or alcoholic is not required.

1.2 Goals and Objectives of Approach

- Enhance the client's motivation for change.
- Teach the client how to break the addictive cycle and establish total abstinence from all mood-altering drugs.
- Teach the client adaptive coping and problemsolving skills required to maintain abstinence over the long term.
- Support and guide the client through troublespots and setbacks that might otherwise lead to relapse.

1.3 Theoretical Rationale/Mechanism of Action

This approach views psychoactive drug addiction as a multidetermined addictive behavior and maladaptive (self-medication) coping style with biological, psychological, and social components. Accordingly, treatment must provide the structure, support, and feedback required to break the behavioral cycle of compulsive psychoactive drug use and provide opportunities to learn adaptive (nonchemical) problemsolving skills to prevent relapse.

1.4 Agent of Change

This approach actively promotes the development of a strong therapeutic alliance between client and counselor along with positive bonding among clients within a group. To ensure continuity of care, each client receives both group and individual therapy from the same counselor.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

Drug addiction is seen as a multidetermined addictive behavior and maladaptive (self-medication) coping style with biological, psychological, and social components. Although initial exposure to psychoactive drugs may have resulted largely from social and cultural factors (including peer pressure), the driving force behind continued and repeated use of these drugs (before pharmacological and physiological addiction set in) is an attempt to qualitatively and quantitatively alter one's experience and internal feeling states. Psychoactive drugs are used by certain (predisposed) individuals to amplify, modulate, obliterate, or transform certain feelings in ways they have been unable to achieve by other (nonchemical) means.

2. CONTRAST TO OTHER COUNSELING APPROACHES

2.1 Most Similar Counseling Approaches

This approach contains many original elements (Washton 1989) and incorporates features of other approaches, including motivational counseling techniques described by Miller and Rollnick (1991), relapse prevention (RP) strategies described by Marlatt and Gordon (1985), and psychodynamic techniques described by Brehm and Khantzian (1992).

2.2 Most Dissimilar Counseling Approaches

The hallmarks of this approach are clinical flexibility and careful attention to individual differences. As such, it contrasts sharply with aggressive confrontational approaches commonly found in traditional treatment programs. Participation in Alcoholics Anonymous (AA) or other self-help programs is actively encouraged and is seen as helpful and highly desirable, but it is not mandatory.

3. FORMAT

Treatment involves a combination of group therapy two to four times a week supplemented by individual counseling once a week. A supervised urine sample is taken from every client at least twice a week, and breathalyzer tests are administered on a random basis throughout the program. Although group therapy is the core treatment modality for most clients, those who refuse to enter group therapy are given the option of individual counseling two to three times a week. Many of these clients subsequently agree to enter group therapy once they have formed a positive relationship with their individual counselor and worked through their initial concerns about participating in a group. Some clients are not able to tolerate group as a result of psychiatric and/or interpersonal impairments. Treatment for these clients may consist of individual therapy two to three times a week, including urine and breathalyzer testing.

3.1 Modalities of Treatment

Group and individual counseling are delivered within the context of a structured yet flexible multistage outpatient treatment program that also includes PE for both the primary client and his or her family; supervised urine testing to encourage and verify abstinence; and, where indicated, pharmacotherapy for coexisting psychiatric disorders.

3.2 Ideal Treatment Setting

This approach was developed within an outpatient treatment setting and as such recognizes that the client is continuously faced with the pressures and stressors of daily life and with easy access to a wide variety of psychoactive drugs. It also recognizes that in the outpatient setting the client is always free to drop out of treatment; accordingly, strong emphasis is placed on therapeutic engagement and retention strategies, particularly at the beginning of treatment when outpatient dropout rates are highest.

3.3 Duration of Treatment

A distinguishing feature of this program is its variable-length format. The length of a client's participation in the program from admission through completion ranges from 12 weeks to 24 weeks as determined by objective measures of clinical progress (i.e., providing clean urines, attending scheduled sessions, developing a sober support network that includes involvement in self-help, and exercising adaptive [nondrug] problemsolving skills). A prespecified set of behavioral contingencies adjusts the length of treatment according to individual need. The average number of sessions from admission to completion is approximately 40.

3.4 Compatibility With Other Treatments

Operating from a basic philosophy of using whatever seems to work best, this approach is naturally compatible with a variety of other treatments. The program has no antimedication bias so long as the medications being offered are clinically appropriate and noneuphorigenic. Where appropriate, naltrexone and disulfiram are utilized to foster RP. Clients with diagnosed psychiatric disorders are treated with psychotropic medication (e.g., antidepressants, antipsychotics) as clinically required. The program does not dispense methadone or other addictive drugs.

3.5 Role of Self-Help Programs

The program actively encourages but does not mandate the client's participation in AA, Cocaine Anonymous (CA), Narcotics Anonymous (NA), or other self-help groups. All clients are given a basic orientation to self-help and what it has to offer that professional treatment does not. They are also given a list of meetings in their community and provided with a buddy (fellow group member) if they feel hesitant or uncomfortable about attending self-help meetings alone. Clients are not threatened with termination from treatment for failure to attend self-help meetings, nor is their reluctance or refusal to attend self-help meetings seen as intractable resistance or denial. The overwhelming majority of clients in the program do, in fact, attend self-help meetings.

4. COUNSELOR CHARACTERISTICS AND TRAINING

4.1 Educational Requirements

A master's degree in social work, counseling, or psychology is the minimum educational requirement for all clinical staff.

4.2 Training, Credentials, and Experience Required

All counselors must have State certification in clinical social work (C.S.W.), clinical psychology (Ph.D.), or addiction counseling (C.A.C.), plus a minimum of 3 years of full-time clinical experience working in an addiction treatment program (preferably an outpatient program).

4.3 Counselor's Recovery Status

The counselor's status is irrelevant. Counselors are chosen solely on the basis of their demonstrated clinical competence and not on the basis of their recovery status.

4.4 Ideal Personal Characteristics of Counselor

Ideally, the counselor should be warm, empathetic, engaging, tolerant, nonjudgmental, and flexible in interacting with clients. The counselor should have a well-developed observing ego and be able to receive and use constructive feedback, particularly with regard to the types of countertransference and control problems likely to arise with highly ambivalent (resistant) clients. The counselor must have excellent verbal communication skills and be capable of defining and implementing appropriate behavioral limits with clients in a consistently therapeutic (nonpunitive) manner.

4.5 Counselor's Behaviors Prescribed

The counselor's role is to motivate, engage, guide, educate, and retain clients during all phases of the program. Using an array of motivational, client-centered, and problemsolving techniques, counselors are expected to:

- Emphasize the client's strengths rather than weaknesses.

- Join rather than assault (confront) resistance.

- Avoid aggressive confrontation and power struggles.

- Negotiate rather than pontificate treatment goals.
- Emphasize the client's personal responsibility for change.

4.6 Counselor's Behaviors Proscribed

The counselor is cautioned against being dogmatic and controlling, especially in response to reluctant and resistant clients. It is easy for the counselor to lose sight of the fact that the first and foremost goal of treatment is to engage the client in a friendly, cooperative, positive interaction that increases the client's willingness to examine and change his or her drug-using behavior. Counselors are taught how to avoid the most common therapeutic blunders and negative countertransferential responses with drug-abusing clients. These include:

- Predicting abject failure and misery if the client does not follow the counselor's advice.

- Telling the client that what he or she really needs is more drug-related negative consequences to acquire the motivation for change.

- Ignoring discrepancies between the program's goals and the client's goals.

- Feeling frustrated and angry at clients who do not fully comply with the program.

- Wanting to impose negative consequences on noncompliant clients (e.g., depriving them of further help by "throwing them out of treatment") rather than negotiating a change in a treatment plan based on clarification of the client's ambivalence about change.

4.7 Recommended Supervision

The counselor's job is a demanding one, and clinical supervision is required not only to sharpen clinical skills and ensure consistency in treatment approach but also to provide the counselor with emotional support and encouragement. All counselors receive 1 hour of group supervision and 1 hour of individual supervision each week. Supervisors use statistical reports (computer printouts) to monitor each counselor's client caseload and work performance. These reports include data on client retention/completion rates, attendance at sessions, urine test results, and goal attainment ratings. Measures of all counselors' work performance include data on quantity of clinical services provided to clients (i.e., numbers of sessions), responses to positive urine test results and missed sessions, timeliness of followup on clients who drop out or fail to show up for sessions, and counselors' compliance with chart-noting requirements. Supervisors pay special attention to client dropout rates, since retention is a key factor in determining treatment success. Supervisors occasionally sit in on counselors' group sessions to directly observe their therapeutic skills in action. Videotaping and audiotaping of sessions (with the client's written consent) is also used in supervision. In addition to supervisory meetings, there is a daily case conference attended by all counselors for assigning new cases and discussing special problems. Once each month, there is an inservice training session on a specific clinical topic.

5. CLIENT-COUNSELOR RELATIONSHIP

5.1 What Is the Counselor's Role?

The counselor serves a multidimensional role as collaborator, teacher, adviser, and change-facilitator.

5.2 Who Talks More?

In general, the client talks more. However, the counselor does not hesitate to offer education, advice, and guidance where appropriate.

5.3 How Directive Is the Counselor?

The counselor takes an active role, offering specific advice and direction, particularly during the early phases of treatment where immediate behavioral changes are required to establish and maintain abstinence.

5.4 Therapeutic Alliance

One of the most important aspects of the therapeutic alliance (TA) approach is the development of a cooperative relationship between client and counselor. Building a positive TA requires the counselor to start where the client is (i.e., to accept and work within the client's frame of reference). This stands in marked contrast to traditional approaches, which demand that the client submit to the counselor's (program's) frame of reference as the starting point of treatment. For example, if the client at first minimizes the seriousness of his or her drug use problem or rejects the idea that it is a problem at all, the counselor refrains from accusing the client of being in denial (a tactic likely to heighten rather than reduce the client's defensiveness) and instead asks the client to cooperate in a time-limited experiment (usually involving a trial period of abstinence) to assess the nature and extent of his or her involvement with psychoactive drugs. Coerced or mandated clients pose the greatest challenge to getting a TA started. Typically, these clients appear for treatment angry, suspicious, mistrustful, and ready to do battle. Building a relationship under these trying circumstances requires a great deal of clinical finesse on the part of the counselor, who makes every effort to:

1. Empathize with the client's plight and the fact that no one likes to be told what to do.

2. Accept without challenge the client's primary motivation for coming to treatment—to get the coercing agent (e.g., court, employer) "off my [the client's] back."

3. Compliment the client for facing the realities of the situation by showing up at the session.

4. Detach himself or herself as much as possible from the coercing agent and offer to help the client solve the problem or problems that led to the current situation.

6. TARGET POPULATIONS

6.1 Clients Best Suited for This Counseling Approach

This treatment is best suited for clients who meet DSM-IV criteria for psychoactive drug addiction and are able to show up for scheduled sessions at an outpatient clinic. The program admits clients who are actively using alcohol and other drugs and those who have already achieved abstinence as inpatients or outpatients. The program treats all types of chemical addiction and cross-addictions irrespective of the client's drug of choice (e.g., alcohol, cocaine, heroin) and has been used successfully with both adult and adolescent populations (treated separately). Chronically unemployed, dysfunctional clients are treated in separate groups from clients with substantially higher levels of psychosocial functioning. The program is coeducational, but a special women's group is available for those who prefer to be treated in an all-female environment. A special dual-focus group (separate from the mainstream program) accommodates the special needs of clients with concurrent psychiatric illness.

6.2 Clients Poorly Suited for This Counseling Approach

Poorly suited candidates for this approach include clients whose psychosocial functioning is so impaired that they are unable to show up for treatment sessions and those who are actively suicidal, psychotic, or otherwise psychiatrically unstable and in need of more structured, intensive care such as an inpatient or partial hospitalization program.

7. ASSESSMENT

The pretreatment evaluation process begins by asking the client to fill out an extensive self-administered assessment questionnaire (the Washton Institute Intake Evaluation Form) (Washton 1995) immediately prior to a 1-hour, face-to-face clinical interview with the intake counselor. The assessment questionnaire covers the domains of:

1. Drug use.
2. Motivation and readiness for change.
3. Psychiatric history and status.
4. Family history.
5. Vocational history.
6. Criminal history.
7. Treatment history.

During the subsequent clinical interview, the counselor seeks to clarify and expand the information already provided by the client on the assessment form. Perhaps more importantly, the counselor makes an active attempt to motivate and engage the client in a therapeutic interaction. Where indicated, the pretreatment evaluation process may require one or more additional sessions and may also include a formal psychiatric assessment. An extremely important aspect of the pretreatment evaluation is assessment of the client's motivation and readiness for change. This involves identifying with the client both internal and external factors currently driving him or her to at least explore the possibility of change. It also involves helping the client identify his or her ambivalence about stopping psychoactive drug use by objectively exploring both the positive and negative effects of the use and by defining the client's treatment goals and to what extent these are consistent with the program's goals. With regard to treatment goals, some clients want to reduce rather than completely stop using their drug of choice, while others want to give up only the one drug causing them the most obvious problems (e.g., cocaine) but not the drugs they view as relatively innocuous and nonproblematic (e.g., alcohol and marijuana). Clients who want to enter an early abstinence group must agree to stop using all psychoactive drugs (total abstinence) for at least a trial period. Clients who do not agree to meet this requirement are offered the option of time-limited individual counseling (up to 6 weeks) to help move them toward accepting trial abstinence as a short-term treatment goal.

During treatment, clinical progress is measured throughout each client's participation in the program. A computerized office management system stores, analyzes, and reports clinical data on all clients during the course of their participation in the program. These data include:

1. Urine test results.
2. Attendance at scheduled sessions.
3. Counselor ratings of the client's progress toward achieving specified treatment goals.
4. Client's self-ratings of progress toward achieving treatment goals.

The data are reviewed monthly (or weekly, if needed) to continuously adjust the treatment to individual client needs, provide supervisory feedback to counselors, and improve overall treatment effectiveness.

Followup treatment studies have been conducted on sample populations at 1- to 2-year intervals after treatment. Followup measures include assessments of:

1. Drug use.
2. Psychosocial functioning.
3. Involvement in self-help.
4. Utilization of other treatment resources.

8. SESSION FORMAT AND CONTENT

8.1 Format for a Typical Session

A typical group session in the early abstinence phase of the program begins with each client stating the length of his or her clean and sober time (i.e., how long ago the client last used any psychoactive drugs whatsoever) and what issue he or she wishes to discuss in that session. Every client is expected to identify at least one issue for discussion at each session. The therapist (group leader) may pull together the issues of two or more group members into a theme for that session or, alternatively, may begin the session with a specific topic as part of a revolving PE sequence. In general, two group sessions per week are devoted to day-to-day concerns and struggles raised by the clients themselves (with appropriate guidance and framing of the discussion supplied by the group leader); one session is devoted to a specific PE or skills-training topic where the counselor presents a brief lecture and guides a focused discussion.

8.2 Several Typical Session Topics or Themes

Following is a partial list of topics and themes in the PE sequence (Washton 1989, 1991): tips for quitting; finding your motivation to quit; how serious is your problem—taking a closer look; identifying your high-risk situations; coping with your high-risk situations; dealing with cravings and urges; why total abstinence—is it really necessary to give up everything?; warning signs of relapse; rating your relapse potential—a realistic assessment; tips for handling slips; managing anger and frustration; finding balance in your life; how to have fun without getting high; defining your personal goals; managing problems in your relationships; building your self-esteem; nutrition and personal health; AIDS and other sexually transmitted diseases—how to avoid them; overview of treatment and recovery; how your family can help without hurting—a look at coaddiction.

8.3 Session Structure

The purpose of each session is to enhance the client's motivation for change and improve his or her ability to cope adaptively with the problems of everyday life without reverting to psychoactive drug use. To accomplish this task success-fully, sessions are neither highly structured nor totally unstructured. The PE sessions serve more to stimulate discussion than present material in a didactic manner. The group leader takes an active role in helping each group member relate the lecture topic to his or her own personal situation. The goal is to foster emotional and behavioral change rather than merely supply factual information.

8.4 Strategies for Dealing With Common Clinical Problems

Lateness and absenteeism are addressed therapeutically as behavioral manifestations of a client's ambivalence about change. The importance of clients arriving at sessions on time and attending reliably is emphasized throughout the program, starting with the initial intake interview. Clients are instructed not to come to the clinic within 12 hours of any alcohol or other drug use. If a client arrives showing clear-cut behavioral signs of intoxication (e.g., slurred speech, uncoordinated movements, breath smelling of alcohol), he or she is asked to leave the premises and return the next day. If the client is severely intoxicated, a counselor will try to contact a family member to escort the client home. According to the program's variable-length treatment protocol, each unexcused absence extends by 2 to 4 weeks the time required for program completion. On the occasion of a third unexcused absence or fifth unexcused lateness, the client is transferred from the early abstinence group to a stabilization group that focuses more intensively on overcoming early obstacles to change.

8.5 Strategies for Dealing With Denial, Resistance, or Poor Motivation

Enhancing a client's motivation for change is an essential part of the counselor's role in this approach. Labeling a client as being in denial, resistant to change, or poorly motivated is seen as distinctly unhelpful. Problems in complying with the treatment program are framed in terms of the client's ambivalence, reluctance, and fears about change. The counselor works collaboratively and cooperatively with the client to overcome these obstacles. In the face of noncompliance, the counselor actively seeks to join the client's resistance and find creative ways around it. This approach recognizes that, especially in the outpatient setting, aggressive confrontation is likely to precipitate dropout from treatment and may nullify efforts to engage and retain clients. It is important to mention that although this approach avoids the use of confrontational tactics, it does not promote a laissez-faire, anything-goes attitude toward client noncompliance. Limit setting and constructive feedback are essential features of the approach that are used in the spirit of enhancing a client's motivation for change rather than insisting that he or she admit to being an addict in serious denial.

8.6 Strategies for Dealing With Crises

In the event of emergencies or crisis situations during nonclinic hours, counselors and supervisors can be paged via a 24-hour telephone answering service. Crises are met with supportive interventions to stabilize the crisis situation and prevent relapse and dropout. The client is provided with frequent individual counseling sessions until the immediate crisis situation is stabilized.

8.7 Counselor's Response to Slips and Relapses

Slips are treated as avoidable mistakes and manifestations of ambivalence. The thoughts, feelings, circumstances, and chain of setup behaviors leading up to the slip are carefully reviewed. The first goal of this debriefing is to help the client recognize and accept the role of personal choice and responsibility in determining drug-using behavior. To decrease the likelihood of further use, an abstinence plan is formulated that incorporates specific decisionmaking, problemsolving, and behavioral avoidance strategies. The variable-length treatment protocol stipulates that each slip increases a client's length of stay in the program by 2 to 4 weeks. On the occasion of a third slip (or sooner if the counselor deems it necessary), the client is transferred to a stabilization group. This group focuses intensively on developing day-by-day (hour-by-hour) behavioral action plans for achieving abstinence. Upon achieving 2 consecutive weeks of total abstinence and perfect attendance in the stabilization group, the client is eligible to return to his or her early abstinence group. In the event of a second slip while in the stabilization group, the client is suspended from group treatment for at least 2 weeks and may be referred for inpatient care. During the suspension, the client may also be given the option of attending the clinic for twice-a-week urine testing and once-a-week individual counseling for a maximum of 4 weeks. If the client achieves 2 consecutive weeks of abstinence during the suspension period, he or she can return to the early abstinence group.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

Active efforts are made to involve significant others (SOs) in the treatment. All newly admitted clients are encouraged to attend a family program together with their SOs (e.g., partner, family members, best friend). The program consists of a conjoint multiple family group that meets once per week for 12 consecutive weeks. The group provides support, education, and counseling geared toward enhancing family members' ability to cope adaptively with their loved one's addiction and teaching them how to break the vicious cycle of enabling and provoking behaviors that perpetuate the problem. Participants learn and practice specific problemsolving and communication skills using guided role-play exercises. Couples and family therapy are also used to deal with problems that require more individualized attention.

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